

DOCUMENT RESUME

ED 192 707

HE 013 195

TITLE Admission of Alien Physicians for Graduate Medical Education: Hearing Before the Subcommittee on Immigration, Refugees, and International Law of the Committee on the Judiciary, House of Representatives, Ninety-Sixth Congress, Second Session on H.R. 7118.

PUB DATE 14 May 80

NOTE 252p.; Not available in paper copy due to marginal legibility of original document.

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.

DESCRIPTORS College Admission; *Compliance (Legal); *Federal Legislation; Federal Regulation; *Foreign Medical Graduates; *Graduate Medical Education; Higher Education; *Hospitals; International Educational Exchange; Medical Services; *Physicians

IDENTIFIERS *Immigration and Nationality Act 1965

ABSTRACT

Congressional hearings on H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of foreign medical graduates for graduate medical education, are presented. The bill would allow an extension of the time by which hospitals are required to reduce their reliance on foreign medical graduates. In particular the bill would authorize: a two-year extension of the substantial disruption waiver authority for those hospitals that make a clear showing by means of a comprehensive plan that they are phasing down reliance on foreign medical graduates by recruiting U.S. medical graduates, improving the quality of the program, and attempting to use alternative health care providers. The bill suggests that the National Health Service Corps should play a prominent part in providing medical services while hospitals and programs develop and implement their plans. Testimony by representatives of the federal government, the City and State of New York, and the medical community are presented. Statements regarding the bill and alternative proposals are appended (SW)

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ADMISSION OF ALIEN PHYSICIANS FOR GRADUATE MEDICAL EDUCATION

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HEARING BEFORE THE SUBCOMMITTEE ON IMMIGRATION, REFUGEES, AND INTERNATIONAL LAW OF THE COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

H.R. 7118

A BILL TO AMEND THE IMMIGRATION AND NATIONALITY ACT
WITH RESPECT TO THE ADMISSION OF ALIEN PHYSICIANS
FOR GRADUATE MEDICAL EDUCATION

MAY 14, 1980

Serial No. 38

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1980

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(III)

OCT 28 1980

ADMISSION OF ALIEN PHYSICIANS FOR GRADUATE MEDICAL EDUCATION

WEDNESDAY, MAY 14, 1980

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON IMMIGRATION,
REFUGEES, AND INTERNATIONAL LAW
OF THE COMMITTEE ON THE JUDICIARY,
Washington, D.C.

The subcommittee met at 1:57 p.m. in room 2237 of the Rayburn House Office Building; Hon. Elizabeth Holtzman (chairwoman of the subcommittee) presiding.

Present: Representatives Holtzman, Hall, Butler, and Lungren.

Also present: Arthur P. Endres, Jr., counsel; James B. Schweitzer, assistant counsel, and Alexander B. Cook, associate counsel.

Ms. HOLTZMAN. The subcommittee hearing on H.R. 7118, relating to the admission of foreign medical graduates will commence. My opening statement will be incorporated at this point in the record. [Material referred to follows:]

OPENING STATEMENT OF HON. ELIZABETH HOLTZMAN

Today's hearing has been called to consider legislation (H.R. 7118), which I have introduced relating to the admission of foreign medical graduates (FMG's) to the United States.

Almost 4 years have passed since Congress passed legislation to insure that only medically and English-language qualified FMG's could enter the U.S. as immigrants or nonimmigrants. Because it was anticipated that the legislation would abruptly reduce the available supply of FMG's that has served many public hospitals for years, the 1976 law attempted to provide a reasonable and orderly transition period. In particular, it authorized a waiver of the Visa Qualifying Examination (VQE) until December 1980 for those institutions which would experience a substantial disruption of health services if FMG's were not available.

Regrettably, many municipal and voluntary hospitals did not take advantage of this grace period and as a result continue to rely heavily—if not exclusively in some instances—on FMG's for house staffing and patient care. The underlying purpose of the 1976 law was to upgrade the educational standards for FMG entry to this country and I do not believe that we can indefinitely postpone the achievement of that objective. Likewise, we cannot continue a system of "second class" medical care for the poor and disadvantaged in our inner-city neighborhoods, who are in many cases totally dependent on FMG's for primary medical care.

On the other hand, I am troubled by the findings contained in a report recently issued by Carol Bellamy, President of the New York City Council to the effect that failure to extend the substantial disruption waiver authority could seriously disrupt medical care in New York City's public hospitals. The report also notes that "FMG's now make up 93 percent of the Health and Hospital Corporation pediatricians in Brooklyn and that new policy could leave the Borough without any children's services in its municipal hospitals."

(1)

To meet this serious and complex problem I have introduced a bill (H.R. 7118) which would allow an extension of the transition period but at the same time require concrete action by the hospitals to reduce their reliance on FMG's. In particular, my bill would authorize: A 2-year extension of the substantial disruption waiver authority for those hospitals which make a clear showing by means of a comprehensive plan that they are phasing down reliance on FMG's by (1) recruiting U.S. medical graduates; (2) improving the quality of the program; (3) and attempting to use alternative health care providers. An additional one year extension authorizing substantial progress has been made by the institution during this 2-year period.

I firmly believe that a longer period—as proposed by some—will unduly delay detailed planning and active recruitment on the part of municipal hospitals. The current problem must be addressed quickly and we must—as my bill does—require comprehensive planning and rigid reporting on the efforts that are being made to once and for all terminate dependency on FMG's.

The bill also reflects my view that the National Health Service Corps should play a prominent part in providing medical services while hospitals and programs develop and implement their plans. By deeming hospitals receiving waivers as Health Manpower Shortage areas and allowing National Health Services Corps personnel to count residence toward their service obligation, we could insure an orderly and smooth phase out of FMG reliance.

In order to discuss the difficult issues surrounding the FMG problem and to comment on my proposal, I have invited officials from the Federal Government, the City and State of New York and the medical community to testify today before the Subcommittee. We welcome our witnesses here today and we anxiously await your testimony.

[A copy of H.R. 7118 follows:]

96TH CONGRESS
2D SESSION

H. R. 7118

To amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs.

IN THE HOUSE OF REPRESENTATIVES

APRIL 22, 1980

Ms. HOLTZMAN introduced the following bill; which was referred jointly to the Committees on the Judiciary and Interstate and Foreign Commerce

A BILL

To amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs.

- 1 *Be it enacted by the Senate and House of Representa-*
- 2 *tives of the United States of America in Congress assembled,*
- 3 That (a) section 212 of the Immigration and Nationality Act
- 4 (8 U.S.C. 1182) is amended by striking out the semicolon at
- 5 the end of paragraph (32) of subsection (a) and inserting in
- 6 lieu thereof a period and the following: "For the purpose of
- 7 this paragraph and subsection (j)(1)(B), an alien who is a
- 8 graduate of a medical school shall be considered to have

1 passed parts I and II of the National Board of Medical Ex-
2 aminers examination if the alien was fully and permanently
3 licensed to practice medicine in a State on January 9, 1977,
4 and was practicing medicine in a State on that date;"

5 (b)(1) Subsection (j) of such section is amended by strik-
6 ing out "Commissioner of Education" and "Secretary of
7 Health, Education, and Welfare" each place it appears and
8 inserting in lieu thereof "Secretary of Education" and "Sec-
9 retary of Health and Human Services", respectively.

10 (2) Paragraph (1)(B) of such subsection is amended—

11 (A) by striking out "(ii)" and inserting in lieu
12 thereof "(ii)(I)"; and

13 (B) by inserting "(II)" before "has competency",
14 "(III)" before "will be able to adapt", and "(IV)"
15 before "has adequate prior education".

16 (3) Such subsection is further amended—

17 (A) by striking out "(including any extension of
18 the duration thereof under subparagraph (D))" in para-
19 graph (1)(C);

20 (B) by amending subparagraph (D) of paragraph
21 (1) to read as follows:

22 "(D) The duration of the alien's participation in
23 the program of graduate medical education or training
24 for which the alien is coming to the United States is
25 limited to the time typically required to complete such

1 program, as determined by the Director of the Interna-
2 tional Communications Agency at the time of the
3 alien's entry into the United States, based on criteria
4 established in coordination with the Secretary of
5 Health and Human Services; except that the alien
6 may, once and not later than two years after the date
7 the alien enters the United States as an exchange visi-
8 tor or acquires exchange visitor status, change the
9 alien's designated program of graduate medical educa-
10 tion or training if the Director approves the change
11 and if a commitment and written assurance with re-
12 spect to the alien's new program have been provided in
13 accordance with subparagraph (C)."; and

14 (C) by striking out "December 31, 1980" in para-
15 graph (2)(A) and inserting in lieu thereof "December
16 31, 1982 (an additional one-year extension may be
17 granted, until December 31, 1983, in the case of a
18 program which the Secretary of Health and Human
19 Services finds has substantially reduced its reliance on
20 aliens who are graduates of foreign medical schools
21 and has made substantial progress in carrying out its
22 plan as described in clause (ii) in 1981 and 1982)".

23 (4) Paragraph (2)(A) of such subsection is amended—

1 (A) by striking out "and (B) of paragraph (1)" and
2 inserting in lieu thereof "and (B)(ii)(I) of paragraph
3 (1)";

4 (B) by inserting after "if" the following: "(i) the
5 Secretary of Health and Human Services determines,
6 on a case-by-case basis, that"; and

7 (C) by striking out the period at the end and in-
8 serting in lieu thereof the following:

9 " , and (ii) the program has a comprehensive plan to reduce
10 reliance on alien physicians, which plan the Secretary of
11 Health and Human Services finds, in accordance with crite-
12 ria published by the Secretary, to be satisfactory and to in-
13 clude the following:

14 "(I) A detailed discussion of specific problems that
15 the program anticipates without such waiver and of the
16 alternative resources and methods (including use of
17 physician extenders and other paraprofessionals) that
18 have been considered and have been and will be ap-
19 plied to reduce such disruption in the delivery of health
20 services.

21 "(II) A detailed description of those changes of
22 the program (including improvement of educational and
23 medical services training) which have been considered
24 and which have been or will be applied which would

1 make the program more attractive to graduates of
2 medical schools who are citizens of the United States.

3 "(III) A detailed description of the recruiting ef-
4 forts which have been and will be undertaken to at-
5 tract graduates of medical schools who are citizens of
6 the United States.

7 "(IV) A detailed description and analysis of how
8 the program, on a year-by-year basis, has phased down
9 and will phase down its dependence upon aliens who
10 are graduates of foreign medical schools so that the
11 program will not be dependent upon the admission to
12 the program of any additional such aliens after Decem-
13 ber 31, 1982."

14 (5) Paragraph (2)(B) of such subsection is amended by
15 inserting at the end the following: "The Secretary of Health
16 and Human Services, in coordination with the Attorney Gen-
17 eral and the Secretary of State, shall (i) monitor the issuance
18 of waivers under subparagraph (A) and the needs of the com-
19 munities (with respect to which such waivers are issued) to
20 assure that quality medical care is provided, and (ii) review
21 each program with such a waiver to assure that the plan
22 described in subparagraph (A)(ii) is being carried out and that
23 participants in such program are being provided appropriate
24 supervision in their medical education and training.

1 “(C) The Secretary of Health and Human Services, in
2 coordination with the Attorney General and the Secretary of
3 State, shall report to the Congress at the beginning of each
4 fiscal year (beginning with fiscal year 1981) on the distribu-
5 tion (by geography, nationality, and area of specialty) of for-
6 eign medical graduates in the United States who have re-
7 ceived a waiver under subparagraph (A), including an analy-
8 sis of the dependence of the various communities on aliens
9 who are in medical education or training programs in the
10 various medical specialties.”.

11 (c)(1) The amendments made by subparagraphs (A) and
12 (B) of subsection (b)(3) shall apply to aliens entering the
13 United States as exchange visitors (or otherwise acquiring
14 exchange visitor status) on or after January 10, 1978.

15 (2) Section 602 of the Health Professions Educational
16 Assistance Act of 1976 (Public Law 94-484), added by sec-
17 tion 307(q)(3) of Public Law 95-83, is amended by striking
18 out subsections (a) and (b).

19 (3) The Secretary of Health and Human Services, after
20 consultation with the Attorney General, the Secretary of
21 State, and the Director of the International Communications
22 Agency, shall evaluate the effectiveness and value to foreign
23 nations and to the United States of exchange programs for
24 the graduate medical education or training of aliens who are
25 graduates of foreign medical schools, and shall report to Con-

1 gress, not later than two years after the date of the enact-
2 ment of this Act, on such evaluation and include in such
3 report such recommendations for changes in legislation or
4 regulations as may be appropriate.

5 SEC. 2. (a) Section 332 of the Public Health Service
6 Act (42 U.S.C. 254e) is amended by adding at the end the
7 following new subsection:

8 "(i)(1) Any public or private nonprofit hospital with an
9 accredited residency training program for which a waiver has
10 been granted (within the previous 12 months) under section
11 212(j)(2)(A) of the Immigration and Nationality Act shall be
12 deemed to be a health manpower shortage area described in
13 subsection (a)(1).

14 "(2) For the purpose of assignment of Corps members
15 under sections 333 and 752(d), a hospital described in para-
16 graph (1) shall be considered among the facilities with the
17 greatest health manpower shortage, and assignment of Corps
18 members shall, whenever possible, reduce the number of
19 alien graduates of foreign medical schools in residency train-
20 ing programs in such hospitals."

21 (b) Section 334(b) of such Act (42 U.S.C. 254g(b)) is
22 amended by inserting after paragraph (3) the following new
23 paragraph:

24 "(4) In the case of one or more Corps members assigned
25 to a hospital described in section 332(i)(1), if the hospital can

1 demonstrate to the satisfaction of the Secretary that the posi-
2 tion available for the Corps member or members (whether in
3 a residency training program pursuant to section 752(d)(2) or
4 as a practitioner pursuant to section 333) is attributable to
5 the termination of one or more positions filled by an alien
6 graduate of a foreign medical school in a residency training
7 program within the previous 12 months, the Secretary shall
8 waive the application of the requirement of subsection (a)(3)
9 to the extent that the rate of payment otherwise required to
10 be paid to the United States under such subsection exceeds
11 the rate of payment made by the hospital to such alien.”.

12 (c)(1) Subsection (a) of section 752 of such Act (42
13 U.S.C. 294u) is amended by inserting “subsection (d)(2) and”
14 after “Except as provided in”.

15 (2) The third sentence of subsection (b)(5)(A) of such
16 section is amended by striking out “No period” and inserting
17 in lieu thereof “Except as provided in subsection (d)(2), no
18 period”.

19 (3) Subsection (d) of such section is amended by insert-
20 ing “(1)” after “(d)” and by adding at the end the following
21 new paragraph:

22 “(2) An individual may choose to perform such individ-
23 ual’s residency as a member of the Corps in a hospital’s pro-
24 gram described in section 332(i)(1), and the period in such
25 residency shall be counted toward satisfying the individual’s
26 period of obligated service under this subpart.”.

Ms. HOLTZMAN. Our first witnesses are a panel of Government witnesses: Michael Glass, General Counsel, the International Communication Agency; and Henry Foley, Administrator, Health Services Administration.

TESTIMONY OF MICHAEL A. GLASS, GENERAL COUNSEL, UNITED STATES INTERNATIONAL COMMUNICATION AGENCY, ACCOMPANIED BY JOSEPH A. BLUNDON, ASSISTANT GENERAL COUNSEL, AND MARY HITT, WAIVER REVIEW OFFICER; AND HENRY FOLEY, ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY FITZHUGH MULLAN, DIRECTOR, NATIONAL HEALTH SERVICE CORPS, AND KEN MORITSUGU, DIRECTOR, DIVISION OF MEDICINE, HEALTH RESOURCES ADMINISTRATION

Mr. GLASS. I would be happy to start by making a suggestion, Ms. Holtzman. I am Michael Glass. My colleague, Mr. Joseph Blundon, Assistant General Counsel, and Mrs. Mary Hitt, one of our waiver review officers, are with me today.

If it fits with your way of proceeding, if we could have about 4 minutes to highlight our particular concerns, we could then answer questions.

Maybe Dr. Foley—

Ms. HOLTZMAN. Dr. Foley, would you identify the people with you?

Dr. FOLEY. The person on my immediate right is Dr. Fitzhugh Mullan. To his immediate right is Dr. Moritsugu, Director of the Division of Medicine in the Health Resources Administration.

Ms. HOLTZMAN. Thank you very much. Without objection, the statement of Mr. Glass and the statement of Mr. Foley will be included in the record at this point.

[The complete statements follow:]

PREPARED STATEMENT OF MICHAEL A. GLASS, GENERAL COUNSEL, U.S. INTERNATIONAL COMMUNICATION AGENCY

Madam Chairwoman, members of the subcommittee: I am pleased to testify before this subcommittee on a matter which I regard as most important from the point of view of the public health, commercial interests and, particularly from the point of view from which I will be speaking, the foreign relations of the United States. I am General Counsel of the United States International Communication Agency ("USICA") and am accompanied by Joseph A. Blundon, Esq., Assistant General Counsel. USICA, is comprised of the former United States Information Agency ("USIA") and the Bureau of Educational and Cultural Affairs of the Department of State, which were consolidated into a single agency by Reorganization Plan No. 2 of 1977. Among its activities, USICA operates the Voice of America, and a network of libraries and information centers around the world designed to inform the peoples of other nations about the United States of America, its people and its policies. USICA also has primary responsibility within the Executive Branch for international educational and cultural exchange programs, including those programs under which alien graduates of foreign medical schools come to the United States as exchange visitors to receive advanced medical education or training and then return to their native countries to use the skills acquired here to improve the health and welfare of their fellow citizens.

Immediately after acquiring responsibility for the exchange visitor programs, USICA became aware that Public Law 94-484, which included an amendment to § 212 of the Immigration and Nationality Act (8 U.S.C. § 1182), and as amended

by Public Law 95-83, was having a deleterious effect on the role of the United States as the recognized leader among nations in providing advanced medical education. Public Law 94-484, as amended, reduced to a maximum of three years the length of time a foreign medical graduate could remain in the United States as an exchange visitor pursuing a program of advanced medical education or training. This, in most cases, involves a residency or fellowship program designed to qualify such a foreign medical graduate to take the examination required to become a certified medical specialist.

At the present time, we are told, only three medical specialty certifying boards (those in internal medicine, general practice and pediatrics) will examine doctors for certification after as little as three years of residency or equivalent fellowship training. The average training time requirement for all medical specialties is four and one-half years, and the maximum (psychiatry with a sub-specialty in psychoanalysis) is twelve years. As a result of the enactment of Public Law 94-484, since January 10, 1978, all foreign medical graduates interested in studying in the United States with a view to becoming specialists—except for those in internal medicine, general practice or pediatrics—have been told at the outset that they will not be allowed to remain here long enough to complete the required training. Under prior law, the permitted visit was limited to five years, with provision for extension in appropriate cases.

The United States has for many years been the recognized leader in providing advanced medical training to the physicians and surgeons of the world. They have come here, studied, qualified as specialists, and gone home to contribute to the development of their native countries and to become prominent and influential citizens, and, in many cases, officials in hospitals, universities and governments. They and the institutions with which they have become affiliated, as can be reasonably inferred, have proved to be good customers for American medical and scientific equipment and pharmaceuticals. Equally important, they constitute a reservoir of public opinion and political influence favorable to the United States in their home countries.

Since the effective date of Public Law 94-484, the number of foreign medical graduates in the United States pursuing advanced medical education and training has decreased from 5,000 on January 10, 1977, to 2,578 on January 10, 1979, and about 2,000 on January 10, 1980. That number is continuing to go down. Further, USICA has received numerous expressions of anxiety and distress from other nations, notably Saudi Arabia, Venezuela, Mexico, Ecuador, Bolivia, Panama, Iceland, Egypt and Cyprus, all of which have in the past relied primarily on the United States for the advanced medical training of their doctors. At the same time we have become aware that the Soviet bloc is taking advantage of the situation by sharply increasing recruiting efforts among doctors, particularly in developing countries, offering liberal scholarships and fellowships for full-term graduate medical education and training. In 1978, from Panama alone, more than one hundred persons who in the past would have normally come to the United States have gone to communist countries to pursue their medical studies.

This unfortunate trend will continue until the Congress acts to amend Section 212(j) of the Immigration and Nationality Act along the lines set forth in section (b) (3) (B) of H.R. 7118. The first foreign medical graduates who came to the United States as exchange visitors after January 10, 1978, will be reaching their mandatory return dates around July 1980. All who are required to leave then will not be eligible to re-apply for admission until they have spent at least two years in their home countries; meanwhile, the flow of new medical exchange visitors will continue to decrease. The only results can be a retreat from the premier position America has held in worldwide medical education and training, a diminution of American assistance to developing nations and to the health of the peoples of the world. The need for such legislation is immediate and urgent, and USICA strongly supports enactment of section (b) (3) (B) of H.R. 7118, with a minor amendment which I will mention presently.

It has also been called to USICA's attention that Public Law 94-484 has cut off a major source of the resident physicians and surgeons to hospitals who, in the course of pursuing their advanced medical education and under supervision by fully certified specialists, provide much of the day-to-day medical care provided to the U.S. public. The foreign medical graduate residents who were already here when the new law took effect are gradually being required to return home pursuant to Section 212(e) of the Immigration and Nationality Act, and very few new ones are coming in because, except for internists, pediatricians and general practitioners, they cannot stay long enough to complete a certification program.

Under H.R. 7118, all foreign medical graduates pursuing programs of graduate medical education or training would continue to be tested for English language fluency and medical competence by means of the Visa Qualifying Examination as they now are. They continue to be screened for eligibility and be sponsored as exchange visitors by the Educational Commission for Foreign Medical Graduates, under contract with the International Communication Agency. This section permits a foreign medical graduate, with the approval of the Director of USICA, to change his or her designated program of study no more than once and no later than the end of the first two years following entry into the United States. This section should, however, be amended so as to apply to all foreign medical graduates entering the United States as exchange visitors to pursue programs of graduate medical education for training on and after January 10, 1978 (the effective date of the three-year limitation of Public Law 94-484, as amended). Otherwise, those who came in since that date and before this Bill takes effect will be unfairly discriminated against.

I have discussed section (b) (3) (B) of H.R. 7118 first, because, of all the provisions of the Bill, it is the most important to the International Communication Agency. However, I would also like to express a few observations and comments as to other provisions of the Bill.

Section (a) of the Bill repeals a provision of Public Law 94-484, as amended, which requires any alien graduate of a foreign medical school who was lawfully practicing medicine under the laws of a state as of January 9, 1977, if the doctor desires to retain the status he or she holds under the Immigration and Nationality Act, to become certified by some recognized medical specialty certifying board. Among other things, this would require such a doctor to take and pass the Visa Qualifying Examination ("VQE"), administered by the Educational Commission for Foreign Medical Graduates ("ECFMG") pursuant to Title 8, United States Code, § 1182(a) (32), and to pursue such studies as might be required by a medical specialty certifying board even if the doctor desired only to engage in the general practice of medicine.

USICA understands the unanimous position of various professional medical groups to be that these requirements of Public Law 94-484 are unnecessary and unfair ex post facto burdens on foreign doctors resident in the United States and lawfully practicing medicine under the laws of a state at the time Public Law 94-484 took effect. These groups also feel that licensure of the medical profession is and ought to be a function of the several states, in which the Federal government should intervene only to further some compelling national interest not present here, and therefore support and urge the enactment of section (a) of this Bill.

Section (b) of H.R. 7118 makes further changes in Public Law 94-484 as amended (22 U.S.C. § 1182(j)). One pertains to: (1) the length of time an alien graduate of a foreign medical school may remain in this country as an exchange visitor, which I have already discussed. The other pertains to the standards to be applied in granting "substantial disruption" waivers to hospitals and medical schools enabling them to bring in foreign medical graduates to serve in residency programs without having first passed the VQE, and the time period within which such waivers may be granted.

Section (b) (3) (C) amends Public Law 94-484 as amended by imposing more stringent requirements which would have to be met before a hospital or medical college could be granted a waiver of certain requirements of Public Law 94-484 (e.g., the VQE) in utilizing exchange visitor foreign medical graduates where necessary to avoid substantial disruption of medical services to the public. It extends to December 31, 1983 the time during which such waivers could be granted. It also requires that the requesting institution file comprehensive and detailed plans for reduction of reliance on alien physicians, and, in seeking waivers after December 31, 1982, demonstrate substantial progress in actually reducing such reliance.

An Inter-agency Substantial Disruption Waiver Appeal Board has been in existence for more than a year, under the Chairmanship of the Administrator of the Health Resources Administration ("HRA"), Department of Health and Human Services ("HHS"). It includes members from HHS, the Immigration and Naturalization Service, the Department of State, and the International Communication Agency, and has developed its own guidelines and standards based on the statute for approving "substantial disruption" waivers. Those guidelines and standards already mandate most, if not all, of the things which Section (b) (3) (C) and succeeding sections would require, and the Board, with the

assistance of HMA and ECFMG, has been highly successful in monitoring compliance by hospitals and medical colleges with the requirements of Title 8, United States Code, § 1182(j) (2) (A), and in ensuring that the overall purposes of the medical exchange visitor programs are carried out. For these reasons, the provisions of sections (b) (3) and (4) of the Bill are redundant to present practice and may be unnecessary.

Section (b) (5) would direct that: "The Secretary of Health and Human Service in coordination with the Attorney General and the *Secretary of State*, shall (i) monitor the issuance of waivers under subparagraph (A) and the needs of the communities (with respect to which such waivers are issued) to assure that quality medical care is provided, and (ii) review each program with such a waiver to assure that the plan described in subparagraph (A) (ii) is being carried out and that participants in such program are being provided appropriate supervision in their medical education."

And that: "The Secretary of Health and Human Services, in coordination with the Attorney General and the *Secretary of State*, shall report to the Congress at the beginning of each fiscal year (beginning with fiscal year 1981) on the distribution (by geography, nationality, and area of specialty) of foreign medical graduates in the United States who have received a waiver under subparagraph (A), including an analysis of the dependence of the various communities on aliens who are in medical education or training programs in the various medical specialties."

I suggest that because primary responsibility for international educational and cultural exchange visitor programs, including those involving foreign medical graduates, was transferred to the International Communication Agency from the Department of State by Reorganization Plan No. 2 of 1977, the words "the Director of the International Communication Agency" should be substituted for the words "the Secretary of State" in these two paragraphs. With that substitution, USICA would have no objection to these provisions of Section (b) (5).

Section (c) (3) of the Bill would provide as follows:

"The Secretary of Health and Human Services, after consultation with Attorney General, the Secretary of State, and the Director of the International Communications [sic] Agency, shall evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools and shall report to Congress, not later than two years after the date of the enactment of this Act, on such evaluation and include in such report such recommendations for changes in legislation or regulations as may be appropriate."

USICA agrees that such a study and evaluation of exchange visitor programs for foreign medical graduates is desirable and supports enactment of this section. As I already mentioned, however, the Secretary of State no longer has any function or responsibility for exchange visitor programs, and I suggest that participation in such a study and evaluation would impose an unnecessary burden on the Secretary. As to those provision of H.R. 7118 not specifically commented on above, the International Communication Agency defers to the views of the Secretary of HHS.

Madam Chairwoman, I shall be happy to respond to any questions which you or other members of the Subcommittee may have.

PREPARED STATEMENT OF HENRY A. FOLEY, PH. D., ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Madam Chairwoman and members of the subcommittee: I am pleased to have the opportunity to appear before you today to discuss the provisions of H.R. 7118, which would amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education and make other legislative changes relating to the utilization in the United States health-care system of foreign medical graduates (FMGs).

The immigration of FMGs to the United States began in earnest in 1948 with the passage of the U.S. Education and Information (Smith-Mundt) Act. This educational exchange Act facilitated the coming of FMGs to the United States for medical residency training at a time when the number of residency positions

available in this country was increasing more rapidly than the number of U.S. trained physicians. Many FMGs who came as exchange visitors later altered their immigration status to become full immigrants and stay beyond the length of their educational program.

By the mid-1970s, the growing number of FMG exchange visitors and immigrants was giving rise to major concerns. There was considerable variation in the quality of medical training among countries. Testing by the Educational Commission for Foreign Medical Graduates (ECFMG) was believed to establish only a minimal level of medical competence. Many FMGs also had minimal fluency in the English language. As American medical schools expanded their enrollments, the need for FMGs to fill residency positions was declining. Finally, FMGs often were not returning home to allow their country to benefit from their American education, which meant that, from an international perspective, there was a "skill drain" of valuable medical talent from foreign countries into the United States.

Title VI of the Health Professions Educational Assistance Act of 1976, Public Law 94-484, mandated a number of changes in policies relating to the issuance of exchange visitors and selected immigrant visas to FMGs. Under current requirements, alien physicians wishing to enter the United States as immigrants on the basis of their skills (under preference categories 3 or 6) or as nonpreference immigrants must pass Parts I and II of the National Board of Medical Examiners' (NBME) examination (or an equivalent examination as determined by HHS, such as the Visa Qualifying Examination) and be competent in written and oral English. The Secretary of Labor must provide certification for alien physicians wishing to immigrate under other than family-related preference.

Alien physicians may no longer enter the United States as exchange visitors (J visa) to obtain graduate medical education or training unless:

A school of medicine (or other accredited health professions school) and a affiliated hospital have agreed in writing to provide the training or to assume responsibility for arranging for the training by an appropriate public or private non-profit institution or agency;

The alien has passed Parts I and II of the NBME examination (or the equivalent), is competent in written and spoken English, will be able to adapt to the educational and cultural environment, and has adequate prior training;

The alien is committed to return to his country and his country has given written assurance that there is a need for persons with the skills being acquired in the U.S. training program; and

The alien will stay no more than two years unless additional training (one year maximum) is requested specifically by his country.

Two of the exchange visitor requirements (relating to school affiliation and passage of examinations) may be waived for an alien until December 31, 1980, if otherwise there would be a "substantial disruption" in the health services provided by the graduate medical education program in which the alien seeks to participate. In granting waivers, the Attorney General must assure that the total number of aliens participating in graduate medical programs at any time does not exceed the number of aliens participating on January 10, 1978, when the new J-visa requirements took effect.

Alien physicians who are in the United States as exchange visitors and who wish to apply for permanent resident status are no longer eligible, simply on the basis of permission from their country, for a waiver of the requirement that they first return to their country for a two-year period.

Alien physicians are no longer allowed to enter the United States as persons "of distinguished merit and ability" coming to perform "services of an exceptional nature requiring such merit and ability" (H-1 visa) unless they have a specific invitation from a public or nonprofit private educational or research entity to teach or conduct research or do both. H visas are no longer available to aliens coming to the United States to perform temporary services as members of the medical profession (H-2 visa) or to receive graduate medical education or training (H-3 visa).

Madam Chairwoman, H.R. 7118 would attempt to ameliorate several problems that have arisen in the application of these new FMG requirements. First, the bill would amend existing legislative restrictions on the entry of alien physicians to make it unnecessary for a physician who was fully and permanently licensed and practicing in a State before January 10, 1977 (the effective date of the new examination requirement for foreign physicians) to have also held on that date

a specialty certificate, in order to be exempt from the requirement of passing Parts I and II of the National Board of Medical Examiners' Examination or an equivalent examination.

We favor on equity grounds the provision for a "grandfather clause" for physicians who were in active practice in the United States when the new restrictions went into effect. Under current law such physicians are exempt from the examination requirement only if they were Board certified specialists on that date. A specialty certificate has never been needed to practice medicine in this country. We would like to make it clear, however, that State licensure in itself would not be regarded as equivalent to passage of Parts I and II of the National Board of Medical Examiners' Examination for aliens entering the country after the effective date of the new requirements. The Visa Qualifying Examination has been determined to be the equivalent examination for this purpose.

Second, the bill would relax the present strict limit on the number of years an FMG exchange visitor may stay in the United States to complete residency training. The bill would allow participants in graduate medical education programs to remain in the U.S. for "the time typically required to complete such program, as determined by the International Communications Agency (ICA), based on criteria established in coordination with the Secretary of the Department of Health and Human Services." In addition, the exchange-visitor would be able to change his/her program once, but not later than two years after entry.

Because many FMG exchange visitors need more than the existing maximum of 3 years to complete needed graduate medical education, we favor an extension in the length of stay allowed. The Administration's bill on this matter, H.R. 7058, specifies that the time limits for any individual would be determined on the basis of the published requirements of officially recognized medical specialty certifying boards and criteria established in coordination with the Secretary of Health and Human Services. For aliens not pursuing full medical specialty certification programs, the determination would be made on such other basis as the Director of the International Communications Agency and the Secretary of HHS found to be in the public interest.

Third, the bill proposes to extend the "substantial disruption" waiver authority through December 31, 1982, with a possible one-year extension to December 31, 1983, for programs which have substantially reduced their reliance on alien foreign medical graduates (FMGs). In addition, there are requirements placed on the Department of HHS to coordinate, monitor, publish regulations and submit reports to Congress on various aspects of the waiver provisions.

The waiver provision mechanism, i.e., review of applications by the Educational Commission for Foreign Medical Graduates (ECFMG) and by the Federal-level Substantial Disruption Waiver Appeal Board, has been operational for two years (calendar years 1978 and 1979). Applications have been submitted from all regions of the Nation, although the Northeast and Central Northeast have been most heavily represented in the applicant pool.

Criteria for implementation of the program were developed after extensive analysis of the expected national and regional impact of the amendments of 1976. During the two years it has been possible to make approval/disapproval decisions at the Tier I level (ECFMG-review level which does not require departmental action) in sufficient numbers (70 program requests) to reduce the load at the Federal level to a manageable number (50 program requests). This has allowed the waiver provision to be implemented efficiently, equitably, and effectively.

The administration of the current waiver provision has included stringent requirements for detailed narratives on (1) the service-related problems associated with a potential reduction in FMGs; and (2) the plans for reducing dependence on FMGs. However, this requirement has been placed on Tier II level applications.

Fourth, H.R. 7118 would require that any public or private nonprofit hospital which has received a "substantial disruption" waiver for alien FMGs during the previous 12 months be automatically designated a health manpower shortage area. The bill further would provide that such areas automatically be considered among the areas with the greatest need for placement of National Health Service Corps personnel.

The designation of areas, population groups and facilities as health manpower shortage areas is based on objective criteria with the involvement of local health planning and other agencies knowledgeable of particular local circumstances.

The purpose of this process is to determine areas, population groups, and facilities which have the greatest need for National Health Service Corps personnel in order that we may best deploy our limited resources.

The criteria now used to demonstrate "substantial disruption" are of two types. Those used for Category A and C waivers depend only on the percentages of the training program slots which were occupied by foreign physicians on January 10, 1978. Those used for Category B and D waivers also involve indicators that the facility involved is serving a shortage area or underserved population; specifically, that the facility is located in a primary medical care manpower shortage area designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid patients.

It should be emphasized that public and nonprofit hospitals themselves may be designated as shortage areas and of course may be serving shortage areas (although they do not necessarily do so, even when they are located near underserved populations). It should also be pointed out that alien FMGs who do not have a permanent resident visa and who are employed by hospitals are excluded from the physician count in the designation process. Thus, hospitals do not face an impediment in being designated by reason of having large numbers of alien FMGs. This existing provision is sufficient to enable hospitals with waivers to fully and fairly compete for the limited resources of the National Health Service Corps.

Within the limits of our resources, we support the placement of fully qualified National Health Service Corps personnel in hospitals which have qualified as health manpower shortage areas under the present law. For the same reason, we oppose the approach used in H.R. 7118. Additional special considerations are unwarranted and could result in the diversion of significant numbers of National Health Service Corps personnel from areas more in need. Moreover, we believe that the primary purpose of the NHSC is the placement of primary care physicians in medically underserved areas and the highest priority areas are those with no primary care physicians.

The fact that the bill proposes that, by law, hospitals with waivers be among those with the "greatest need," could, in practical effect, give such hospitals priority for placements over, among others, remote Indian reservation sites, prisons, and mental health facilities. We believe, as in the case of other facilities, population groups or areas, that the hospitals in question should earn their relative priority based on their actual circumstances and not by operation of a special law.

While the number of hospitals from which waiver applications have been received in the two calendar years has not been large (i.e., 57), the extent to which the applicant pool will expand in the future is not known. A recently completed study confirmed the apparent serious situation in the Northeast, particularly in New York City, but found no major concern in other parts of the Nation. However these findings were based on a small sample of hospitals. There is some concern that the New York City situation will soon be repeated in several other urban areas.

The bill is not clear as to whether it is meant that a hospital which receives a "substantial disruption" waiver for, say, its anesthesiology program, would be designated as a shortage area for anesthesiologists only, for primary care physicians as well, or for any and all specialties.

If the intent or the effect were to be to consider such a hospital as a shortage area for all specialties because of a problem identified for one specialty, this would be even more damaging to the National Health Service Corps Scholarship and placement programs.

Fifth, the bill would allow the assignment of Corps physicians to residency positions in "waivered" hospitals, with each year of residency training to be credited as a year of obligated service for Corps Scholarship recipients. Madam Chairwoman, this provision raises problems in respect to quality of care provided under the Corps program and to equity in the application of service obligation requirements.

Many hospitals that have developed a dependency on alien FMG residents use them in large part for providing ambulatory primary health care to the population of the area it serves. Before we assign a NHSC provider to an area we require that they complete at least one year of clinical training, and we are required by law to defer those who wish to seek advance training for up to three years and

In certain cases even longer. We believe these provisions enable us to insure that, when the National Health Service Corps assigns physicians to an area or facility, the assignees will furnish high quality health care. Currently, two-thirds of NHSC physicians have completed residency training and are board eligible or board certified. The practice of relying on residents, be they domestic graduates or alien FMGs, for primary care is not in the interest of optimal medical care.

We believe that there is an important distinction between backfilling residencies and placing fully qualified primary care physicians in a hospital. The latter, which we support, requires organizational and other institutional changes to see that a proper and high quality ambulatory primary health care setting is in place.

We understand that the transition from dependence on alien FMGs to structuring residency programs attractive to American graduates is difficult and time consuming. And, for this reason, we support the extension of waivers and the Administration has submitted legislation to provide a simple extension of the waiver authority (H.R. 6800).

We also believe the elements of the plan required for such hospitals to decrease their dependence on alien FMGs under H.R. 7118 has merit. The plan will require that they explore other alternatives such as appropriate use of physician assistants, and describe changes in their program designed to attract domestic graduates and institute active recruitment efforts to attract these graduates. A well developed and executed plan of this nature will not be easy but should be sufficient to enable hospitals to reduce the number of their alien FMG residents. Such a plan goes to the root problem and is the appropriate course of action for these hospitals and should govern Federal Government intervention. Reliance on special legislation to secure NHSC personnel, often at the expense of more worthy areas, does not address the causes of the problem and may be detrimental to the overall aims of the NHSC Program.

The proposed provision would have the effect of considerably diffusing the NHSC's current focus on primary care, since the residency training programs heavily filled by alien FMGs include not only general practice, pediatrics, psychiatry, and child psychiatry, but also such specialties as anesthesiology, pathology, physical medicine, nuclear medicine, and therapeutic radiology. Also, if NHSC Scholarship recipients were to be allowed to fulfill their obligations by residency in these fields, this would tend to shift them away from the primary care orientation which the NHSC Scholarship Program and many other programs authorized under the Health Professions Educational Assistance Act of 1976 have been promoting.

The most disruptive aspect of the provision in H.R. 7118 for assigning Corps physicians to hospitals as residents, however, is that it would establish a basic inequity in the National Health Service Corps. Some scholarship obligees—those serving in hospitals with waivers—would have the opportunity of fulfilling their residency training while at the same time serving their scholarship obligation. We would be expending approximately \$60,000 to train a physician so that we could be repaid by that physician's entering and serving in a training program. It should be noted that under H.R. 7118 the residency training need not even involve direct patient care. Other obligees serving residencies and who may be providing primary care to needy patients would be denied this benefit.

This "double credit" has the potential of being so attractive that it may frustrate our matching efforts—which hopefully lead to retention—and thwart an appropriate rural/urban balance. This is particularly true when the attractiveness of the "double credit" is coupled with the statutory "need" priority for those hospitals and with the fact that service as a resident would be at the choice of the scholarship recipient. We know from experience under prior legislation that such an inequity can cause serious difficulties and morale problems with little benefit to the National Health Service Corps.

Finally, the bill provides that if an NHSC assignment to a waived hospital is due to termination of positions filled by alien physicians, the hospitals will only owe the Federal Government the amount they would have paid the alien FMGs.

All entities that have the benefit of NHSC personnel are subject to repay the Federal Government for the salary and proportionate share of scholarship costs for each assignee. Currently that is approximately \$39,000 per physician assignee per year. We do not believe hospitals with waivers for alien FMGs should be given special consideration.

Again, we should stress that we have no difficulty in granting waivers of repayment to hospitals or other entities when conditions warrant. Indeed, as a consequence of our efforts to place NHSC personnel in the most needy areas, our collections for salary and scholarship costs have been low.

One exception is that of State and local entities. It is the Administration's policy that the National Health Service Corps should not be used to subsidize functions such as prison health and the operation of mental health institutions which traditionally have been the function of State and local governments.

In brief, the National Health Service Corps is available and should be used to assist in ameliorating the many difficulties of hospitals still dependent on alien FMGs. The National Health Service Corps can be of significant assistance to these institutions. Other programs such as the Community Health Center program and the Hospital-Affiliated Primary Care Center program can also be of great help in addressing the problems of these hospitals. We stand ready to aid these hospitals, but firmly believe they must compete for Federal resources on the same footing as other entities.

Madam Chairwoman, this concludes my testimony. I would be happy to answer any questions.

Ms. HOLTZMAN. Mr. Glass, perhaps you ought to briefly summarize the contents of your testimony.

Mr. GLASS. Certainly. The first point we would like to make is in our area of expertise, communicating the foreign policy of the United States abroad. Doctors in other countries—especially in developing countries—whether or not they make their living in intergovernment service, always become centers of community leadership and influence. If we can favorably impress the medical community abroad, we have achieved a very significant foreign policy objective.

The present law is, one might say, goring the foreign policy of this country increasing a barrier to reaching doctors. It imposes a 2-year limitation, with the possibility of a 1-year extension on the length of time alien graduates of foreign medical schools may spend here pressuring advanced medical training leading to anticipation as a specialist.

I think all specialties require more than 3 years of sustained study in this country; and, therefore, most foreign doctors, who came here for advanced training know that they will have to interrupt their careers by changing horses in midstream. This is a disincentive to both them personally as well as to the government which—in most cases—are providing some sort of support for their studies.

Therefore, there has been—as one can expect—a significant falloff in the number of foreign medical graduates coming here. Two years ago there were slightly more than 5,000. This past January, the figure has been halved; and one can expect that this downward trend will continue.

There are also commercial implications for the United States in the sale of its medical products abroad which shouldn't be ignored.

This bill, in section (3) (b) does exactly the right thing. It makes the residency period coterminous with the specialty which the foreign medical graduate has selected. It also, intelligently I think, adds a degree of flexibility into the procedure. People should be allowed, within reason, to change their minds; and if within the first 2 years of his stay he changes his mind and selects another specialty, in appropriate cases, the Director of the U.S. ICA can grant an extension of stay if needed.

Along the following lines, the bill should do something better: In subsection (b) (3)–(5), it extends this kind of coterminous and flexible

treatment to new arrivals after the effective date of the act. There is no reason this shouldn't be grandfathered so people, whenever they arrived, can take advantage of this unproved approach.

I would also like to comment on two general tendencies I have seen since coming to the Government: The first is a needless proliferation of detail. If you will take a look at section (B) (4) of the bill, you will see—think beginning on page 3, carrying over—an awful lot of text which is guidance to one of the review panels, the Substantial Disruption Waiver Appeal Board, on the type of findings they have to make.

It's my information that this Appeal Board is now following substantially all, if not all, of these guidelines; and to proliferate detail by putting this in legislation I don't think would be helpful.

My suggestion is that the oversight, your justifiable desire for oversight, be accomplished in the following way: Under section (C) (3) of the bill, in 2 years the committee gets a report. I think if that section were to add the provision that the committee also be told about how the Waiver Review Panel has been operating, how they've been applying these guidelines set out in the draft bill, and what kind of suggestions they make for loosening or tightening or otherwise changing these procedures, the Appeal Board will have some flexibility and a chance to operate on its own. The committee has oversight and can look at the whole area and decide whether it needs to place in legislation or not.

This provision is beginning to look like the esoteric parts of the Internal Revenue Code, which is not something desirable to be achieved.

My second general point has to do with the needless layering of authority. Under reorganization plan No. 2 of 1977—which created the U.S. International Communication Agency—all of the educational and cultural exchange programs, of which foreign medical graduates program is an important part, were transferred from the Bureau of Educational and Foreign Affairs in the Department of State to the new agency.

There is nothing left in the Department of State which focuses on educational and cultural exchange programs. By statute, my agency takes foreign policy guidance from the Secretary of State. If any issue in the context we are discussing rises to the level of a foreign policy consideration, we consult with the Department at the appropriate level.

The Secretary of State has many things to do these days, and I don't know that having him serve on the various commissions, various committees, and so forth—which are specified in section (b) (4) and (5) of the bill—really helps the process at all, nor does it lighten his workload.

That's all I have to say. I have just one concluding remark. When the chairwoman and I were at law school together, I—and many others of that generation—decided to go to law school rather than medical school because I couldn't stand the sight of other people's blood; therefore, we find it somewhat ironic and amusing that my first appearance before any part of the Judiciary Committee is an area having to do with medical science and doctors, except I can make the link,

however, that I am very happy to be here, because—as I said at the outset—it is our foreign policy which is being gored.

Ms. HOLTZMAN. Thank you very much, Mr. Glass.

Dr. Foley, would you be good enough to summarize your testimony briefly for the benefit of the subcommittee?

Dr. FOLEY. Thank you, Madam Chairwoman.

I would like to suggest that H.R. 7118 attempts to ameliorate several problems relating to the application of these new FMG requirements, the requirements coming out of the 1976 law. I would like to summarize those.

First, the bill would amend existing legislative restrictions on the entry of alien physicians to make it unnecessary for a physician who was fully and permanently licensed and practicing in a State before January 10, 1977 to have also held on that date a specialty certificate, in order to be exempt from the requirement of passing parts I and II of the National Board of Medical Examiners' examination or an equivalent examination.

We favor on equity grounds the provision for a "grandfather clause" for physicians who were in active practice in the United States when the new restrictions went into effect.

Second, the bill would relax the present limit on the number of years an FMG exchange visitor may stay in the United States to complete residency training. The bill would allow participants in graduate medical education programs to remain in the United States for "the time typically required to complete such program, as determined by the International Communications Agency * * *." We clearly favor that.

Third, the bill proposes to extend the "substantial disruption" waiver authority through December 31, 1982, with a possible 1-year extension to December 31, 1983, for programs which have substantially reduced their reliance on alien foreign medical graduates. In addition, there are requirements placed on the Department of Health and Human Services to coordinate, monitor, publish regulations, and submit reports to Congress on various aspects of the waiver provisions.

We support the extension of waivers and the administration has submitted legislation to provide a simple extension of the waiver authority, H.R. 6800, to December 31, 1983.

The waiver provision mechanism has been operational for 2 calendar years, 1978 and 1979. Applications have been submitted from all regions of the Nation, although the Northeast and Central Northeast have been most heavily represented in the applicant pool.

They have been reviewed by the Educational Commission and by the Federal-level Substantial Disruption Waiver Appeal Board, which I chair.

The criteria for implementation of the program were developed after extensive analysis of the expected national and regional impact of the amendments of 1976. During these 2 years it's been possible to make approval/disapproval decisions at the tier I level, that is the ECFMG-review level, which does not require departmental action, insufficient numbers to reduce the load at the Federal level to a manageable number. There are 50 program requests. This has al-

lowed the waiver provision to be implemented efficiently, equitably, and effectively.

The administration of the current waiver provision has included stringent requirements for detailed narratives on the service-related problems associated with a potential reduction in FMG's; and, second, the plans for reducing dependence on FMG's. However, these requirements have been placed only on tier II level applications.

We also believe the elements of the plan required in H.R. 7118 for hospitals to decrease their dependence on FMG's has merit. The plan would require us to explore other alternatives, a description of changes in the present program designed to attract domestic graduates, and the institution of active recruitment efforts to attract these graduates.

We support this because this is the way the current board actually functions in its requirements. A well-developed and executed plan of this nature will not only be easy but should be sufficient to enable hospitals to reduce the number of their alien FMG residents.

Fourth, H.R. 7118 would require that any public or private non-profit hospital which has received a "substantial disruption" waiver for alien FMG's during the previous 12 months be automatically designated a health manpower shortage area. The bill would further provide that such areas automatically be considered among the areas with the greatest need for placement of National Health Service Corps personnel.

The designation of areas, population groups and facilities as health manpower shortages is based on objective criteria with the involvement of local health planning and other agencies knowledgeable of particular local circumstances. The purpose of the process is to determine areas, population groups, and facilities which have the greatest need for National Health Service Corps personnel in order that we may best deploy our limited resources.

The criteria now used to demonstrate "substantial disruption" are of two types. Those used for category A and C waivers depend only on the percentages of the training program slots which were occupied by foreign physicians on January 10, 1978. Those used for category B and D waivers also involve indicators that the facility involved is serving a shortage area or underserved population; specifically, that the facility is located in a primary medical care manpower shortage area designated under section 332 of the Public Service Act, or had more than 25 percent medicaid patients.

It should be emphasized that public and nonprofit hospitals themselves may be designated as shortage areas and, of course, may be serving shortage areas—although they do not necessarily do so, even when they are located near underserved populations. It should also be pointed out that alien FMG's who do not have a permanent resident visa and who are employed by hospitals are excluded from the physician count in the designation process. Thus, hospitals do not face an impediment in being designated by reason of having large numbers of alien FMG's. We think this existing provision is sufficient to enable hospitals with waivers to fully and fairly compete for the limited resources of the National Health Service Corps and that additional special considerations are unwarranted.

For that reason we oppose the approach in this regard proposed by H.R. 7118.

Within the limits of our resources, we support the placement of fully qualified National Health Service Corps personnel in hospitals which have qualified as health manpower shortage areas under the present law. Moreover, we believe that the primary purpose of the National Health Service Corps is the placement of primary care physicians in medically underserved areas and the highest priority areas are those with no primary care physicians.

The bill is not clear as to whether it is meant that a hospital which receives a "substantial disruption" waiver for, say, its anesthesiology program would be designated as a shortage area for anesthesiologists only, for primary care physicians as well, or for any and all specialties.

It would be damaging to the National Health Service Corps scholarship and placement programs if the intent or the effect was to consider such a hospital as a shortage area for all specialties because of a problem identified for one specialty.

Fifth, the bill would allow the assignment of corps physicians to residency positions in "waivered" hospitals, with each year of residency training to be credited as a year of obligated service for corps scholarship recipients. Madam Chairwoman, this provision raises problems in respect to quality of care provided under the corps program and to equity in the application of service obligation requirements.

Many hospitals that have developed a dependency on alien FMG residents use them in large part for providing ambulatory primary health care to the population of the area it serves. Before we assign a National Health Service Corps provider to an area we require that they complete at least 1 year of clinical training, and we are required by law to defer those who wish to seek advance training for up to 3 years and in certain cases even longer. We believe these provisions enable us to insure that, when the National Health Service Corps assigns physicians to an area or facility, the assignees will furnish high quality health care.

Currently, two-thirds of National Health Service Corps physicians have completed residency training and are board eligible or board certified. The practice of relying on residents, be they domestic graduates or alien FMG's, for primary care is not in the interest of optimal medical care.

The most disruptive aspect of the provisions in H.R. 7118 for assigning corps physicians to hospitals as residents, however, is that would establish a basic inequity in the National Health Service Corps. Some scholarship obligees—those serving in hospitals with waivers—would have the opportunity of fulfilling their residency training while at the same time serving their scholarship obligation. We would be expending approximately \$60,000 to train a physician so that we could be repaid by that physician's entering and serving in a training program. It should be noted that under H.R. 7118 the residency training need not even involve direct patient care. Other obligees serving residencies and who may be providing primary care to needy patients would be denied this benefit.

Finally, the bill provides that if a National Health Service Corps assignment to a waivered hospital is due to termination of positions filled by alien physicians, the hospitals will only owe the Federal Government the amount they would have paid the alien FMG's.

All entities that have the benefit of National Health Service Corps personnel are subject to repay the Federal Government for the salary and proportionate share of scholarship costs for each assignee. Currently that is approximately \$39,000 per physician assignee per year. We do not believe hospitals with waivers for alien FMG's should be given special consideration.

Again, we should stress that we have no difficulty in granting waivers of repayment to hospitals or other entities when conditions warrant. Indeed, as a consequence of our efforts to place National Health Service Corps personnel in the most needy areas, our collections for salary and scholarship costs have been low.

One exception is that of State and local entities. It is the administration's policy that the National Health Service Corps should not be used to subsidize functions such as prison health and the operation of mental health institutions which traditionally have been the function of State and local governments.

In closing, the National Health Service Corps is available and should be used to assist in ameliorating the many difficulties of hospitals still dependent on alien FMG's. The National Health Service Corps can be of significant assistance to these institutions. Other programs such as the community health center program and the hospital-affiliated primary care center program can also be of great help in addressing the problems of these hospitals. We stand ready to aid these hospitals, but firmly believe they must compete for Federal resources on the same footing as other entities.

Madam Chairwoman, this concludes my testimony. I would be happy to answer any questions.

Ms. HOLTZMAN. Thank you.

Mr. Glass, you state that the detailed language spelling out the review procedures in H.R. 7118 is not necessary because of the present practice. If present practice has been so successful, can you explain to me why the requests for waivers have been increasing and why we are in a situation where the dependency in a number of hospitals, particularly in New York City—but also in other urban areas—has not been diminished?

Mr. GLASS. I can't explain that with any degree of clarity. My point is mainly an institutional one. That is, you have a board that's been operating for 2 years in what before was an uncharted area.

As they go along, they are developing their own criteria. Because of various practical situations, it tends to be dynamic. Rather than tying its board down with as much detail as there is in the statute, if you give them 2 years more and then have a report, you can probably fine tune better in case there is any legislation needed for any specific detail.

Ms. HOLTZMAN. I appreciate your explanation, except it seems to me almost 4 years has elapsed already and you have yet to begin to deal with this serious problem. Very little progress has been made.

Mr. GLASS. It's been 2 years now; and, of course, 2 more are being asked for. That would be 4. They have only been operating 2 years.

Ms. HOLTZMAN. The legislation was enacted almost 4 years ago.

Mr. GLASS. Yes. That's true.

Ms. HOLTZMAN. The gentleman from Texas?

Mr. HALL. No questions.

Ms. HOLTZMAN. I don't have any further questions. Thank you very much for your testimony here today.

Our next witnesses will be from New York State and New York City. First, we will hear from the very distinguished president of the City Council of New York, Carol Bellamy, who will be accompanied by Richard Berman, director of the office of health systems management. Then we will hear from David Mannis, the director of inter-governmental relations of the Health and Hospitals Corp.

TESTIMONY OF CAROL BELLAMY, PRESIDENT, CITY COUNCIL OF NEW YORK, ACCOMPANIED BY BARRY ENSMINGER, COUNSEL; RICHARD BERMAN, DIRECTOR, OFFICE OF HEALTH SYSTEMS MANAGEMENT; AND DAVID MANNIS, DIRECTOR, INTERGOVERNMENTAL RELATIONS, HEALTH AND HOSPITALS CORP., ACCOMPANIED BY ROBERT DeCRESCHE

Ms. BELLAMY. I think we have enough for a basketball team here.

Ms. HOLTZMAN. I want to welcome you before the subcommittee. We are very proud to have the president of the New York City Council, who is one of the most distinguished elected officials not just in New York City but in the country. You have done a great deal of work on this, I know, and we are very pleased to have the benefit of your testimony.

I might say that, without objection, the text of your entire testimony will be incorporated in the record. If you wish, you may summarize, or you can read it.

Ms. BELLAMY. I will attempt to summarize. I appreciate the opportunity to appear before this Subcommittee on Immigration. You have indicated some of the other people at the table: Richard Berman from the State; Dave Mannis from the city; my counsel, Barry Ensminger.

We are here to attempt to respond and offer comments at this point on H.R. 7118. I come before you today as an elected official with special interests in health care.

Over the past 9 months, my office has been examining the role of foreign medical graduates in New York City teaching hospitals. In February, I issued a report, "Is There a Doctor in the House?", which documented the critical physician shortage that New York City and other localities, particularly in the Northeast and Midwest, will face if the present immigration law is not amended.

I have set forth in my testimony—and won't go through it in detail—a bit of history in terms of the issue of foreign medical graduates, dealing first with the issue of the perceived shortage of doctors, the move for a waiver, the subsequent amendments, and the determination of self-sufficiency in terms of doctors in this country, and now the phasing-out period and the critical nature of the phasing-out period.

What I would like to turn to now, if I can provide that information to you for the record in my testimony, is to talk a bit about the New York City situation.

The loss of foreign medical graduates will be most severely felt in the industrialized sections of the Northeast and North Central States.

New Jersey, for example, reported that 58 percent of all interns and residents were FMG's in 1977. In Connecticut, the figure exceeded 70 percent. Over one-third of the teaching hospitals in Illinois, Michigan, Ohio, Maryland, Delaware, and New York had more than 50 percent of their house staff positions filled with alien doctors.

New York City is, and will continue to be, particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. New York City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056—or 38 percent—were foreign medical graduates.

This high proportion of FMG's stems from the problem many New York City hospitals face when recruiting U.S. medical graduates. Elite teaching hospitals in Manhattan can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden hospitals in poor neighborhoods have been difficult in the past and certainly are not getting any easier.

Medical students are uncertain about the future of New York's troubled hospitals; 27 private institutions have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment, and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospitals are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for nearly 40 percent of the interns and residents citywide, the proportion in individual voluntary and municipal hospitals ranges from 7 percent to 100 percent. Foreign medical graduates amount to more than 50 percent of the housestaff—interns and residents—in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75 percent. Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but again many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the FMG's.

The reduced pool of FMG's will cause the greatest problems in hospitals run by the New York City Health and Hospitals Corp. which trains about 40 percent of the foreign graduates in the city.

David Mannis from that agency will speak about some of their plans. I would like to talk again just briefly as to the impact.

If the prediction of a two-thirds reduction of FMG's nationally holds true for New York City, our municipal hospitals alone will lose more than 800 physicians by 1984—one-half the housestaff in pediatrics, child psychiatry, general surgery, and OB/GYN. These losses will jeopardize the delivery of health services where the dependence

on foreign medical graduates is most acute. That is particularly true in two of our boroughs, the boroughs of Brooklyn and the Bronx.

Moreover, there is the strong possibility that New York City hospitals will lose more than two-thirds reduction projected for the entire country. As the nationwide pool of FMG's shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Again, the problems that I spoke about—financial problems and outdated facilities—already put New York City's municipal hospitals at a disadvantage. Applications for internships and residencies dropped 8 percent between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported falloffs from 25 percent to 75 percent. New York's difficulties in recruiting physicians will only be compounded by the immigration restrictions.

One other problem: While foreign medical graduates enter all medical specialties, they have tended to emphasize areas of less interest to American graduates.

More than 80 percent of our FMG's, for example, are in four primary care specialties—medicine, general surgery, pediatrics, and obstetrics/gynecology—and four nonprimary care fields—pathology, psychiatry, anesthesiology, and rehabilitative medicine. FMG's now make up 93 percent of the Health and Hospitals Corp.'s pediatricians in Brooklyn, and the borough could be left without any children's services in municipal hospitals.

In this context, I am giving you some idea of the shape of the problem in our town. I would like to speak briefly about H.R. 7118.

Too many hospitals in New York City and elsewhere have not used the phase-in period already allowed by the Federal Government. Instead, as the pool of available FMG's has diminished, we have seen more and more waiver requests. Obviously, this is not an acceptable solution. Hospitals must develop—and implement—a suitable plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of foreign doctors.

At this late date, however, additional time and Federal assistance is needed to do this job properly. In my opinion, H.R. 7118 would provide that time and assistance; and with one reservation, I support this legislation and hope it will be enacted by the Congress.

This legislation would allow the Federal Government to continue granting waivers to "avoid a substantial disruption of health services" until December 31, 1982, with an additional 1-year waiver available for qualifying institutions. In return for this extension of the phase-in period, hospitals would be required to develop a detailed plan for replacing alien doctors.

I fully support the strict reporting requirements contained in the bill. Having failed to prepare for the impending FMG reduction, hospitals cannot complain about requirements to develop suitable replacement plans. Any additional waiver extensions must be conditioned on firm evidence that hospitals are finally preparing for the phaseout of FMG's.

In fact, I would strengthen these provisions even further. FMG-dependent hospitals should also be required to undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting service delivery. Some FMG's are

filling positions in specialties, such as pathology, that often exist more for teaching purposes than for patient needs. Likewise, other FMG's train in specialties that are considered oversubscribed by the Federal Government. In many cases, these services could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

Having made that statement about more restrictive provisions in terms of reporting, I must say that I am concerned, however, with the extension of the waiver authority to December 31, 1982, with an additional 1 year for hospitals that demonstrate a substantial reduction in FMG dependence. I would recommend a 5-year waiver authority instead.

Some institutions—particularly financially troubled hospitals serving poor and medically indigent patients—will have great difficulty reducing their heavy reliance on foreign doctors. In many cases, this will not reflect the absence of a good faith effort but rather the larger problems of physician maldistribution and the relative unattractiveness of medical practice in poor areas. For these hospitals, the Department of Health and Human Services should be allowed the administrative discretion to continue granting waivers provided that a good faith and substantial effort is made at reducing this dependence on FMG's.

H.R. 7118 amends existing law to coordinate the length of a foreign doctor's stay in the United States with the actual length of the training program. The present 2-year deadline, with an optional third year, is arbitrary. Alien physicians who come to the United States for graduate medical education, and who otherwise qualify for entry, should be allowed to remain here for a period equal to the length of their program. This will enable FMG's to return home with appropriate skills. Here in the United States, medical care will not be compromised by shortages of upper-level resident physicians created by the forced departure of FMG's after 2 years.

Finally, H.R. 7118 provides Federal manpower assistance to FMG-dependent hospitals during the phase-in period. Institutions demonstrating the need for a waiver would qualify for National Health Service Corps placement at no additional cost over and above house-staff salaries. Medical students would be encouraged to seek placement in these programs by allowing the training period to satisfy the corps service obligation.

This assistance would be targeted to communities where it is needed the most. Only hospitals that had successfully obtained a waiver—first, by demonstrating that a substantial disruption of essential health services would otherwise occur, and second, by developing a comprehensive plan for reducing FMG dependence—could qualify for corps personnel.

Furthermore, the Department of Health and Human Services would retain the administrative discretion to assign corps physicians to areas of greatest need. Qualifying hospitals would merely join other medically underserved areas in the competition for corps personnel. This would enable the Federal Government to be a partner in the hospital's comprehensive plan for reducing FMG dependence, when it was appropriate.

In enacting this legislation, Congress should not lose sight of the larger issue of maldistribution—by specialty and geography—of physicians trained here in the United States. Stopgap legislation regarding the FMG cutoff is not a long-term solution. We must redistribute medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class. Ultimately, this depends on reordering the basic priorities of American medical education. It rests with health policymakers, both public and private, and physicians themselves to develop a coherent medical policy to accomplish these goals.

I thank you for the opportunity to appear before the committee.
[The complete statement follows:]

PREPARED STATEMENT OF HON. CAROL BELLAMY, CITY COUNCIL PRESIDENT,
NEW YORK CITY

Chairwoman Holtzman, Honorable Members of the House Judiciary Subcommittee on Immigration. Thank you for the opportunity to testify on H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of alien physicians for graduate medical education.

I am President of the New York City Council. I come before you today as an elected official with a special interest in health care. Over the past nine months, my office has been examining the role of foreign medical graduates in New York City teaching Hospitals. In February, I issued a report, "Is There a Doctor in the House?", which documented the critical physician shortage that New York City and other localities, particularly in the northeast and midwest, will face if the present immigration law is not amended.

Before I comment on the provisions of H.R. 7118, however, I would like to place the issue of foreign medical graduates in context.

Over the past two decades, foreign-born graduates of overseas medical schools have played an increasingly prominent role in the delivery of health services in the United States. They often serve in inner-city hospitals lacking doctors, and enter specialties such as pediatrics, gynecology and anesthesiology, which are frequently shunned by their American counterparts.

Concerned about the nationwide shortage of doctors in the 1960's, the federal government encouraged the influx of foreign medical graduates (or FMG's). The usual immigration requirements were waived for foreign doctors in 1965 amendments to the Immigration and Naturalization Act. These amendments exempted foreign physicians from the national origins quota system, thus providing easier access to the United States. Between 1965 and 1975, an average of 7,375 foreign medical graduates entered the country every year, receiving valuable training in U.S. hospitals and providing essential medical services in return.

Finding the lucrative earning power of American doctors hard to resist, many FMG's converted their temporary permits into permanent visas to stay in the United States. By 1976, FMG's accounted for 85,000—or 21 percent—of the nation's 409,000 physicians. Many of these doctors set up practice in low-income neighborhoods avoided by U.S. medical graduates.

As thousands of foreign doctors stayed in the United States, their native countries felt the impact of the "brain drain". Leaders of underdeveloped countries asked why their nations should provide expensive medical school training to young men and women, only to see them leave to practice in the United States.

At the same time, the need for foreign medical graduates in the United States declined as increasing numbers of doctors graduated from American medical schools. From 1966 to 1977, a 6 percent annual increase in the number of U.S. graduates helped alleviate the physician shortage of the early sixties, nearly doubling the number of U.S. medical graduates. Fears of physician surpluses in many sections of the country were voiced with increasing frequency.

Questions were also raised about the medical qualifications of the FMG's. Critics pointed out that foreign doctors were not scoring as well as American graduates in standardized tests and questioned their proficiency in the English language. Language and cultural barriers often created obstacles to proper treatment and diagnosis, it was argued.

Congress responded to these growing concerns by passing the Health Professions Educational Assistance Act of 1976, declaring the United States self-sufficient in physician manpower and ending the national policy of preferential treatment for foreign medical graduates desiring entry visas. The new law tightened the educational standards and visa qualifications necessary for foreign medical graduates desiring to enter the United States for post-graduate training. It also imposed a two-year time limit on such training programs, with an optional third year if requested by the FMG's home country.

The potential adverse consequences of this change in policy did not go unnoticed. Congress provided a phase-in period which waives the more stringent educational requirements if a particular training program can demonstrate that a "substantial disruption in medical services" would otherwise occur. This phase-in period runs out in December 1980, at which time the more restrictive immigration requirements will have full force and effect.

Thus, the 1976 law greatly reduces the pool of foreign medical graduates eligible for entry into the United States each year; cutting the annual supply of FMG's by two-thirds—from 7,500 to 2,500—by 1980 or 1981, according to a recent forecast by the Department of Health, Education and Welfare. Foreign medical graduates, beginning four to five year long residency programs before December 31, 1980, will still be able to enter the country under the waiver provision. The full impact of the law will not be felt until 1985, when the 1980 group will have graduated, and virtually all foreign medical graduates in the country will have entered under the stricter regulations.

The loss of FMG's will be most severely felt in the industrialized sections of the northeast and northcentral states. New Jersey, for example, reported that 58 percent of all interns and residents were FMG's in 1977.

In Connecticut, the figure exceeded 70 percent. Over one-third of the teaching hospitals in Illinois, Michigan, Ohio, Maryland, Delaware, and New York had more than 50 percent of their housestaff positions filled with alien doctors.

New York City is, and will continue to be, particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. New York City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056—or 38 percent—were foreign medical graduates.

This high proportion of FMG's stems from the problem many New York City hospitals face when recruiting U.S. medical graduates. Elite teaching hospitals in Manhattan can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden hospitals in poor neighborhoods have been difficult in the past and certainly are not getting any easier.

Medical students are uncertain about the future of New York's troubled hospitals; 27 private institutions have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospitals are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for nearly 40 percent of the interns and residents city-wide, the proportion in individual voluntary and municipal hospitals range from 7 percent to 100 percent. Foreign medical graduates amount to more than 50 percent of the housestaff—interns and residents—in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75 percent. Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but again many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the FMG's.

The reduced pool of FMG's will cause the greatest problems in hospitals run by the New York City Health and Hospitals Corporation which trains about 40 percent of the foreign graduates in the City.

If the prediction of a two-thirds reduction of FMG's nationally holds true for New York City, our municipal hospitals alone will lose more than 800 physicians

by 1984—one-half the housestaff in pediatrics, child psychiatry, general surgery and obstetrics/gynecology. These losses will jeopardize the delivery of health services where the dependence on foreign medical graduates is most acute. That is particularly true in 2 of our boroughs, the Boroughs of Brooklyn and the Bronx.

Moreover, there is the strong possibility that New York City hospitals will lose more than the two-thirds reduction projected for the entire country. As the nationwide pool of FMGs shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Again the problems that I spoke about—financial problems and outdated facilities already put New York City's municipal hospitals at a disadvantage. Applications for internships and residencies dropped 8 percent between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported falloffs from 25 percent to 75 percent. New York's difficulties in recruiting physicians will only be compounded by the immigration restrictions. While foreign medical graduates enter all medical specialties, they have tended to emphasize areas of less interest to American graduates.

More than 80 percent of our FMGs, for example, are in four primary care specialties—medicine, general surgery, pediatrics, and obstetrics/gynecology—and four non-primary care fields—pathology, psychiatry, anesthesiology, and rehabilitative medicine. FMGs now make up 93 percent of the Health and Hospitals Corporation's pediatricians in Brooklyn, and the borough could be left without any children's services in municipal hospitals.

In this context, let me turn to H.R. 7118. This is legislation that would not alter the basic federal decision to reduce our dependence on foreign medical graduates.

However, unfortunately, too many hospitals in New York City and elsewhere have not used the phase-in period already allowed by the Federal government. Instead, as the pool of available FMG's has diminished, we have seen more and more waiver requests. Obviously, this is not an acceptable solution. Hospitals must develop—and implement—a suitable plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of foreign doctors.

At this late date, however, additional time and federal assistance is needed to do this job properly. In my opinion, H.R. 7118 would provide that time and assistance; and with one reservation, I support this legislation and hope it will be enacted by the Congress.

This legislation would allow the federal government to continue granting waivers to "avoid a substantial disruption of health services" until December 31, 1982, with an additional one year waiver available for qualifying institutions. In return for this extension of the phase-in period, hospitals would be required to develop a detailed plan for replacing alien doctors.

I fully support the strict reporting requirements contained in the bill. Having failed to prepare for the impending FMG reduction, hospitals cannot complain about requirements to develop suitable replacement plans. Any additional waiver extensions must be conditioned on firm evidence that hospitals are finally preparing for the phase-out of FMGs.

In fact, I would strengthen these provisions even further. FMG-dependent hospitals should also be required to undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting service delivery. Some FMGs are filling positions in specialties, such as pathology, that often exist more for teaching purposes than for patient needs. Likewise, other FMG's train in specialties that are considered oversubscribed by the Federal government. In many cases, these services could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

I am very concerned, however, with the extension of the waiver authority merely to December 31, 1982 (with an additional one year for hospitals that demonstrate a substantial reduction in FMG dependence). I would recommend a five year waiver authority instead.

Some institutions—particularly financially troubled hospitals serving poor and medically indigent patients—will have great difficulty reducing their heavy reliance on foreign doctors. In many cases, this will not reflect the absence of a good faith effort but rather the larger problems of physician maldistribution and the relative unattractiveness of medical practice in poor areas. For these hospitals, the Department of Health and Human Services should be allowed the administrative discretion to continue granting waivers provided that a good faith and substantial effort is made at reducing this dependence on FMGs.

H.R. 7118 amends existing law to coordinate the length of a foreign doctor's stay in the United States with the actual length of the training program. The present two year deadline, with an optional third year, is arbitrary. Alien physicians who come to the United States for graduate medical education, and who otherwise qualify for entry, should be allowed to remain here for a period to the length of their program. This will enable FMG's to return home with appropriate skills. Here in the United States, medical care will not be compromised by shortages of upper level resident physicians created by the forced departure of FMG's after two years.

Finally, H.R. 7118 provides federal manpower assistance to FMG-dependent hospitals during the phase-in period. Institutions demonstrating the need for a waiver would qualify for National Health Service Corps placement at no additional cost over and above housestaff salaries. Medical students would be encouraged to seek placement in these programs by allowing the training period to satisfy the Corps service obligation.

This assistance would be targeted to communities where it is needed the most. Only hospitals that had successfully obtained a waiver—first, by demonstrating that a substantial disruption of essential health services would otherwise occur, and second, by developing a comprehensive plan for reducing FMG dependence—could qualify for Corps personnel.

Furthermore, the Department of Health and Human Services would retain the administrative discretion to assign Corps physicians to areas of greatest need. Qualifying hospitals would merely join other medically underserved areas in the competition for Corps personnel. This would enable the federal government to be a partner in the hospital's comprehensive plan for reducing FMG dependence, when it was appropriate.

In enacting this legislation, Congress should not lose sight of the larger issue of maldistribution—by specialty and geography—of physicians trained here in the United States. Stopgap legislation regarding the FMG cut-off is not a long-term solution. We must redistribute medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class. Ultimately, this depends on reordering the basic priorities of American medical education. It rests with health policy-makers, both public and private, and physicians themselves to develop a coherent medical policy to accomplish these goals.

Thank you for the opportunity to submit my views.

Ms. HOLTZMAN. Thank you very much for your excellent testimony. Will your time schedule allow you to stay while we have the other testimony?

Ms. BELLAMY. Absolutely.

Ms. HOLTZMAN. The next witness is Mr. Richard A. Berman, director of New York State's Office of Health Systems Management.

Mr. Berman, the text of your testimony will be incorporated in the record in full. I would appreciate your summarizing it briefly.

Mr. BERMAN. Thank you very much. We are particularly pleased to have been asked to be here, since you have been a champion of the availability of New York's health services.

In the interests of time—and taking your hint—I will just go to basically the back several pages, which deal specifically with the bill before you.

Again I would also like to thank the president of the city council and her staff. As you can tell from both of our statements, there has been a lot of exchange of information and data; and it gives you some hope that elected officials can still work together.

Specifically, just to run over quickly, I would amend our testimony on page 5 to support the addition of Ms. Bellamy's—what I call—fifth provision, which is a reevaluation of current housestaff physicians in the reporting requirements.

I think up until that point, with the exception of the 3- or 5-year, we are consistent and we would support completely her testimony and thrust.

The one area that we do have a difference in is that from our perspective, it is difficult for us to support the amendments to the Public Health Service Act for which the waiver to either public or private hospitals has been approved, to deem that as a high priority health manpower shortage area.

We would have to oppose that provision, because we believe that through a lot of other considerations, the National Health Service Corps has been a very effective program; but, as with all programs, has a very limited number of positions. Those positions have been allocated by region; and, within a region, those have been designated to provide ambulatory care in underserved areas.

To basically take physicians away from this activity and put them into a hospital, which may not be in a medically underserved area and for which they may not be spending the bulk of their time in the provision of primary care, is one which we cannot support, since we feel that it is a serious problem that we now are facing in a lot of our underserved areas and would not want to see that effort reduced.

The same applies to the use of National Health Service Corps positions and individuals and relieving them of their obligations to serve in primary capacities in underserved areas while they are taking their hospital-based training programs.

With the exception of those provisions, I'm proud to say that we support the testimony of Ms. Bellamy.

[The complete statement follows:]

PREPARED STATEMENT OF RICHARD A. BERMAN, DIRECTOR OF THE NEW YORK
STATE OFFICE OF HEALTH SYSTEMS MANAGEMENT

Ms. Chairwoman, members of the subcommittee, I am Richard A. Berman, Director of the New York State Office of Health Systems Management. I appreciate being able to testify on behalf of the State of New York concerning foreign medical graduates.

The New York State Office of Health Systems Management was created by Governor Carey in 1977, to give a new organizational focus and an increased emphasis to the initiatives being taken by his Administration to ensure that health care services of the highest quality are available to all of New York's people at an affordable price. The power exercised by OHSM's thirteen hundred staff include review and approval of all proposals for development and operation of institutional health programs—certificate of need; monitoring and regulating the delivery of both institutional and noninstitutional health care services; and, setting reimbursement rates and reimbursement policies for a wide range of health care services under several major third-party programs. Moreover, if legislation proposed this year by the Governor is passed by the Legislature, the Office of Health Systems Management will also become New York's single state agency for management of the Medicaid program.

I am particularly pleased that Chairwoman Holtzman is conducting these hearings, because this is a problem which impacts severely on New York State and the City of New York.

Congresswoman Holtzman has championed improved access and availability of essential health care services. Her commitment to these ends is shared by New York State.

Because OHSM's functions encompass efforts to assure access to essential and high quality health services, we are deeply concerned about the problems concerning the loss of foreign medical graduates.

Foreign medical graduates have become an integral part of New York's health care network. In 1976, 40 percent of all non-federal physicians in New York

State were foreign medical graduates, that is, nearly double the national average.¹ Over 47 percent of residencies in New York in 1976, were filled by foreign medical graduates² and almost 70 percent of the medical staff in the State and county mental health hospitals are foreign medical graduates.³

Furthermore, Public Law 94-484, which H.R. 7118 addresses requires two-thirds reduction in immigration of foreign medical graduates in New York State from approximately 3,000 to 1,100.⁴ This reduction, without Congressional intervention, will occur over a short period of time, and is likely to cause problems, especially in the 23 New York City hospitals which have FMG's staffing over 50 percent of their interns and residency positions.⁵ (Attached is a listing of these programs.)

However, this is not a simple problem. In order to understand the problem fully, a review of its history is necessary. During the 1960's and early 1970's, New York State and federal health manpower policy was predicated on the widespread belief that there was a serious shortage of physicians. Consequently, both the state and federal governments began major financial assistance programs to support medical education and expand medical school enrollments.

At the same time, foreign physicians were encouraged to enter this country. Occupational preferences were provided for immigrating physicians, and immigration policy allowed entry to aliens obtaining further graduate medical education. This created a surge of FMGs entering the United States. Between 1963 and 1976, the FMG population increased from 31,000 or 11 percent of all United States physicians, to 85,620 or 20 percent of all United States physicians.⁶ The impact of the influx of FMGs reached a peak in 1972, when 46 percent of new licenses to practice medicine in the United States were granted to FMGs. This ratio has since declined to under 35 percent.⁷

This influx similarly affected the internship and residency programs. Between 1950 and 1973, the national percentage of training programs filled by FMGs increased from 10 percent to 33 percent.⁸ Much of this increase has taken place in the mid-Atlantic region and, specifically, in New York State. For example, although 26 percent of all residencies nationally were filled by FMGs, 45 percent of the positions in the mid-Atlantic region were filled by FMGs, and 47 percent of all positions in New York State were filled by FMGs.⁹ These residencies were especially concentrated in a small number of large teaching hospitals, many of which are part of the New York City Health and Hospitals Corporation.

Throughout the country, the heavy influx of FMGs has led to a dependence of state and county mental health hospitals upon FMG staff. In 1975, over half of these positions nationwide were filled by FMGs. In New York State, over 70 percent of these positions were filled by FMGs in 1975, or over 1,000 FMGs were working in state or county mental hospitals.¹⁰

Foreign medical graduates have clearly had a significant impact on the nation's supply of physicians and have served as a safety valve over the past two decades whereby work forces could induce additions to the physician supply beyond those provided by graduates from the United States educational system.

As a result of the increasing percentage of FMGs in the United States health care system, many substantial concerns have been raised by various parties. For example, the Sun Valley Forum on National Health's Symposium on Foreign Medical Graduates, which in 1975 I had the opportunity to participate in, noted the following concerns:

A. In the view of some persons, United States immigration policy with regard to FMGs drains highly qualified, trained personnel from developing countries

¹ "Toward a Balanced Health Manpower Policy," report of the Task Force on Health Manpower to the New York State Health Advisory Committee. Report of the Short Term Policy Issues, September, 1979, p. 8-31.

² *Ibid.*, p. 23.

³ *Ibid.*, p. 24.

⁴ "Is There a Doctor in the House?" How the Loss of Foreign Medical Graduates Will Affect Health Care Delivery in New York City. Office of the City Council President, February, 1980, p. 2.

⁵ New York State Health Planning Commission, "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals," 1979.

⁶ "Toward a Balanced Health Manpower Policy," p. 23.

⁷ *Ibid.*, p. 23.

⁸ *Ibid.*, p. 23.

⁹ *Ibid.*, p. 23.

¹⁰ *Ibid.*, p. 24.

where they are sorely needed—an unwise and unseemly policy for the United States to follow.

B. Many persons believe that the medical education received by FMGs is different from and often inferior to that offered by United States medical schools and that many FMGs do not provide a quality of medical service that is up to United States standards.

C. Some persons contend that it is unfair and improper for the United States to allow FMGs to come into the country, receive graduate medical training, and enter into the nation's medical system as physicians while at the same time capable young men and women who are United States citizens are denied entry to undergraduate medical school and are thus excluded from careers as physicians.

D. Some persons believe that, given present rates of increase in the number of physicians in the United States, in time there will not be a shortage of physicians but instead a surplus. They fear that such a surplus, if it were to develop, might increase the incidence of improper professional practice, such as the performance of unnecessary medical procedures.

E. Some persons believe that it is inequitable and objectionable that FMGs—some unlicensed—should be the main providers of health care for the poor and ethnic minorities in inner-city areas and for patients in state mental hospitals.¹¹

In summary, encouraging FMG immigration to the United States has had major positive and negative impacts on the United States and foreign health systems. Some of the major positive impacts of increased physician immigration include:

- A drastic increase in the supply of physicians in the United States;

- The admission of talented foreigners seeking full training in medical specialties;

- The provision of substantial amounts of medical services to poor and medically underserved areas;

- The availability of another source of low cost medical manpower;

- The provision of needed physician manpower for public institutions; and,

- The training of foreign physicians who have returned to their native country with needed specialty training.

Unfortunately, some of these positive impacts have also been offset by negative impacts, including:

- An increased cultural and language barrier to patients seeking physical and mental health care;

- An uncertain control on the quality of the skills and training received by FMGs;

- A potential oversupply of physicians generally and in certain specialties;

- A vulnerable dependence of public and voluntary institutions on low-cost manpower, i.e., resident FMGs; and,

- A potential drain of essential medical manpower from the native countries. For example, in 1977, over 39 percent of the residents and interns were from India and Pakistan, which both have an undersupply of physicians and could reattract such physicians.¹²

The climate for this growth clearly changed with the passage by the Congress of the Health Professions Educational Assistance Act of 1976 (Public Law 94-484). Recognizing that "there is no longer an insufficient number of physicians and surgeons in the United States . . .", the Congress concluded "that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act."¹³ This trend has continued to be supported by more recent research. It is projected that Public Law 94-484 has decreased the immigration of FMGs from approximately 7,500 per year to 2,500 per year.¹⁴ In New York State, if Public Law 94-484 is not amended, it is expected to decrease the FMG immigration by two-thirds or from 3,056 in 1978, to less than 1,100 by 1984.¹⁵ Although New York

¹¹ "Sun Valley Forum on National Health, Inc., The Foreign Medical Graduate in the United States Health Care System." Report of the Symposium, Jan. 14-17, 1978, p. 6.

¹² Annual Report on Medical Education in the United States, 1977-78. Journal of American Medical Association, 240: 2837-2846 (1978).

¹³ Public Law 94-484.

¹⁴ "Toward a Balanced Health Manpower Policy," p. 24.

¹⁵ "Is There a Doctor in the House?" p. 2.

State supports the intent of Public Law 94-484, the sudden reduction of foreign physicians will cripple some hospitals and public institutions. Specifically, in 1976, in 23 New York City hospitals over 50 percent of the house staff were FMGs.¹⁴ The impact of FMG reduction on services at these facilities and public institutions such as mental health hospitals may be devastating to the quality and accessibility of care for New York State citizens.

In an effort to assess the potential impact of inevitable FMG reduction, a Task Force of the New York State Governor's Health Advisory Council conducted a study of FMGs. Based on preliminary findings of a survey sample of 18 highly FMG dependent hospitals conducted in 1978, only one hospital reported some negative impact on services for 1978-79. Five hospitals anticipated a negative impact for 1979-80, and four had already taken measures to reduce the impact. Unfortunately, this study and others indicate that many facilities have not adequately planned for what they should have realized to be an immediate and eminent manpower reduction. Although there was no sense of real crisis, the chief executive officers of 13 of the 18 hospitals foresaw problems beginning in July of 1979. Because the New York State Governor's Health Advisory Council Task Force is greatly concerned, they have directed the New York State Health Planning Commission to resurvey these hospitals to determine the impact of the results of the 1960-81 residency matching of New York hospitals. This resurvey is now in progress. The results of this study and subsequent recommendations will direct the needed changes in New York State's response to this problem.

For these reasons, New York State generally supports the efforts of H.R. 7118 to postpone the impact on Public Law 94-484. Specifically, New York State's position on the provisions of this legislation is as follows:

Section (b) (3) (B) states that: "... the duration of aliens' participation is limited to the time typically required to complete such programs ... The alien may, once and not later than two years ... change the alien's designated program ... of training."

New York supports this provision because, if the purpose of these visas are to provide training for FMGs, then the FMGs need to be able to stay long enough to complete the approved programs.

Section (b) (3)(c) extends the date for which waivers are available in cases where there would be substantial disruption in health care services. The provision extends the date from December 31, 1980 to December 31, 1982. (An additional one year extension may be granted by the Secretary of Health and Human Services for programs which have substantially reduced their reliance on FMGs.)

New York State supports this provision which is essential because it gives those hospitals with the greatest dependence on FMGs, time to adapt to the drastic decrease in FMG population.

Section (b) (4) (A) amends the PHS Act, to reflect approval by the Secretary of Health and Human Services of all waivers on a case by case basis.

New York State supports this provision which gives the Secretary greater control over the implementation of these provisions and provides a greater potential for assuring the plans specified below are developed.

Section (b) (4) (C) requires that all facilities requesting waivers prepare a comprehensive plan to reduce reliance on alien physicians. The plan must:

1. Discuss problems that the program anticipates without a waiver and methods that will be applied to reduce disruption of services;
2. Discuss program changes to make the program more attractive to graduates of medical schools who are United States citizens;
3. Discussion of recruitment efforts to attract United States citizens; and,
4. Description of how the program has and will phase down its dependence on FMGs completely by December 31, 1982.

New York State strongly supports this provision. Numerous studies conducted in New York generally show that facilities have inadequately planned for the impacts of Public Law 94-484. Without these additional provisions the facilities will face the same problems in 1983 that they face today.

¹⁴ New York State Health Planning Commission, 1979.

A provision is added that requires the Secretary of Health and Human Services, the Attorney General and the Secretary of State to monitor the issuance of waivers, the needs of the communities, the assurance of quality medical care, and the review of programs receiving waivers to assure appropriate supervision of FMGs.

We support this provision because it is essential that the activities carried out relating to this legislation be closely monitored.

Provisions are added to require a report to Congress in Fiscal Year 1981 and 1982 on waivers granted and to require the Secretary of Health and Human Services to evaluate and report to Congress on the effectiveness and value of exchange programs to graduate training for FMGs within two years of enactment of this legislation.

New York State supports these provisions and believes that it is essential that the Secretary of Health and Human Services report to the Congress yearly on the implementation of this legislation.

The Public Health Service Act is amended to consider that any public or private hospital with an approved residency program for which a waiver has been granted (within the last twelve months) shall be deemed a high priority health manpower shortage area.

New York State opposes this provision. The National Health Service Corps has been a very effective program that has provided essential ambulatory care services in truly medically underserved areas. However, federal appropriations for the NHSC program have not substantially increased, and each region effectively has a cap on the number of NHSC physicians available. As it stands, this provision would drain essential resources away from ambulatory care in medically underserved areas to inpatient care in areas of dubious medical need. This provision is inconsistent with the intent of the NHSC and is not the appropriate route for a long term solution to the FMG problem.

The Public Health Service is amended to allow residency training in programs for which waivers have been granted under Section 212 of the Immigration and Nationality Act, to meet obligations for service for NHSC commitments.

New York State strongly opposes this provision for the same reasons it opposes the previous provision. In addition, the NHSC program would be further undermined by allowing residency training programs to meet the service obligations to the NHSC.

Clearly, H.R. 7118 as a whole, must be viewed in the context of comprehensive manpower: policy and legislation. Substantial changes are taking place in health manpower. Most important to remember is that although HEW's estimates that there will be an excess of physicians by as much as nine percent in the country by 1990,¹⁷ there will continue to be geographic and specialty maldistribution. For example, the problem of over two million New Yorkers currently living in medically underserved areas will not disappear.

H.R. 7118 and all health manpower legislation must be analyzed considering the impacts on: the FMGs; the FMGs' native country; the recognized oversupply of physicians; the specialty and geographic distribution of physicians; the quality of medical care; and the training and service institutions.

Furthermore, the Congress' support of proposals in H.R. 7118 and a reconstruction of the health manpower resources should not be mistakenly considered as the panacea for all health manpower problems. H.R. 7118 does not respond to the additional serious issues of the fates of foreign medical graduates who are United States citizens.¹⁸ It also does not encourage redistribution of physicians geographically and among specialties.

In conclusion, the intent of H.R. 7118 is an essential component of a comprehensive federal health manpower policy. But, the amendments to Section 212 of the Immigration and Nationality Act, especially the provisions noted by facilities thereby correcting deficiencies in previous legislation.

¹⁷ Cited from Barhydt, Nancy R., *Strategies for Reduced Number of Foreign Medical Graduates in New York City Hospitals* Dissertation Columbia University School of Public Health, May, 1979, p. 246.

¹⁸ Fleisher, Philip F., M.D., Dr. Anthony Tartaglia, Dr. Steven Tomas, and Dr. John Siegel, *Report on Problems of United States Citizen Foreign Medical Graduates*. Printed by Association of American Medical Colleges, Jan. 11, 1980.

TABLE 1.—DEPENDENCE ON FOREIGN MEDICAL GRADUATES IN NEW YORK CITY BY HOSPITAL AND INCOME OF CATCHMENT AREA FAMILIES

Hospital	Location	Catchment area families with income less than \$5,000 a year
More than 75-percent foreign medical graduates:		
Bronx-Lebanon ¹	Bronx	30 to 40 percent.
Cumberland	Brooklyn	20 to 30 percent.
Goldwater	Manhattan	Less than 20 percent.
Greenpoint	Brooklyn	More than 40 percent.
Brooklyn-Jewish ¹	do.	Do.
Jewish Memorial ¹	do.	30 to 40 percent.
Kingsbrook ¹	do.	20 to 30 percent.
Methodist ¹	do.	More than 40 percent.
St. Johns Episcopal ¹	do.	20 to 30 percent.
Sydenham	Manhattan	More than 40 percent.
Catholic Medical Center ¹	Brooklyn	Not available.
Flushing ¹	Queens	Do.
51- to 75-percent foreign medical graduates:		
Beekman ¹	Manhattan	More than 40 percent.
Cabrini ¹	do.	Less than 30 percent.
Cady ¹	do.	Do.
Coney Island	Brooklyn	20 to 30 percent.
Elmhurst	Queens	Not available.
Jamaica ¹	do.	More than 40 percent.
Veterans' Administration	Bronx	Not available.
Long Island College ¹	Brooklyn	20 to 30 percent.
St. Vincent's ¹	Staten Island	Do.
Lutheran ¹	Manhattan	30 to 40 percent.
New York Infirmary	do.	Less than 20 percent.
26- to 50-percent foreign medical graduates:		
St. Luke's ¹	do.	30 to 40 percent.
Beth Israel ¹	do.	Less than 20 percent.
Booth ¹	Queens	Not available.
Brookdale ¹	Brooklyn	30 to 40 percent.
Kings County/Downtown	do.	Do.
Harlem	Manhattan	20 to 30 percent.
Staten Island ¹	Staten Island	Do.
Metropolitan	Manhattan	More than 40 percent.
Einstein ¹	Bronx	Less than 20 percent.
Long Island Jewish ¹	Queens	Do.
Maimonides ¹	Brooklyn	Do.
Less than 26-percent foreign medical graduates:		
Bellerose	Manhattan	Do.
Bronx Municipal	Bronx	Do.
Lanox Hill ¹	Manhattan	Do.
Mount Sinai ¹	do.	More than 40 percent.
Montefiore ¹	do.	Less than 20 percent.
New York University ¹	do.	Do.
St. Vincent's ¹	do.	30 to 40 percent.
New York Hospital ¹	do.	Less than 20 percent.
Misericordia ¹	Bronx	Do.
New York Eye and Ear ¹	Manhattan	Do.
Presbyterian ¹	do.	30 to 40 percent.
Roosevelt ¹	do.	Less than 20 percent.

¹ Voluntary hospitals.

Source: "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals," New York State Health Planning Commission, 1979.

Ms. HOLTZMAN. Thank you.

We have as our next witness David Mannis, who is the director of intergovernmental relations of the Health and Hospitals Corp.

Mr. Mannis, the text of your testimony, without objection, will be incorporated fully in the record at this point.

[The statement follows:]

PREPARED STATEMENT OF DAVID MANNIS

Madam Chairman and subcommittee members: I am David Mannis, Director of Intergovernmental Relations for the New York City Health and Hospitals Corporation. I have asked Dr. Bob DeCresce of the Downstate Medical College to join me today to assist in answering any questions you may have.

First, I would like to say, on behalf of Joseph Hoffman, President of the Health and Hospitals Corporation, how pleased he is that this subcommittee has focused its attention on the troublesome question of foreign medical graduates and to express his appreciation for the opportunity to comment on H.R. 7118.

The Health and Hospitals Corporation operates the seventeen municipal hospitals of the City of New York. These hospitals have a combined complement of eleven thousand beds and provide over three million inpatient days of care and some six million emergency room and clinic visits each year. The hospitals serve neighborhoods where few if any private physicians practice, and treat populations too poor to pay hospital bills or private insurance premiums. (As you know, Madam Chairman, the Corporation counts among its patients many of the large population of illegal aliens which presently drain the resources of the City in so many ways.)

To serve the City's poor and near poor, Corporation hospitals are generally located in the City's least desirable neighborhoods. Since they operate with all the constraints of a municipal agency and provide health care for so many non-paying patients, substantial deficits and restrictions on quality of service cannot be avoided. Accordingly, our hospitals simply cannot compete with many of the voluntary hospitals in New York City for the services of graduates of American medical schools.

As a result, the Corporation now employs over 1,500 foreign medical graduates as interns, residents and staff physicians. Our dependence on FMG's is not a matter of choice; but for FMG's, programs in many Corporation hospitals would have no applicants for house officer positions.

At the end of this year existing provisions of the Immigration and Nationality Act prohibit entry of all but a few foreign medical graduates. The Health and Hospitals Corporation has viewed this deadline with great concern. It has been clear to us, however, that it would not be appropriate to request any extension of the deadline without preparing a plan for complying with Congress' avowed policy of reducing hospitals' dependence on foreign medical graduates.

I have submitted to this subcommittee copies of a working paper devised by the Corporation which sets forth in some detail all the strategies which we are preparing to reduce the number of FMG's in our hospitals. I would like to summarize those strategies today, and comment on some of the problems facing us in carrying them out.

First, the Corporation is willing to aggressively recruit U.S. medical graduates, but it is unrealistic to count on improved recruitment to overcome the innate disadvantages of our hospitals which deflect medical graduates to voluntary facilities.

A more productive approach would be to recruit American graduates of foreign medical schools. These schools appear anxious to place students in our hospitals, but at the present time the State of New York has called into question the suitability of some of these schools, and until the State determines which schools if any are acceptable, it will be difficult to initiate training programs for USFMG's.

We would like to see students who receive State assistance while attending medical school to exchange forgiveness of student loans for assignments in hospitals in urban medically underserved areas. This requires action by the State Legislature, which we are seeking at this time.

If appropriate interns and residents are unavailable, the Corporation is prepared to hire staff physicians and physician extenders to provide services now performed by FMG's. The cost of such personnel would be immense, since they command higher salaries—and work far shorter hours—than interns or residents. We estimate that it would cost one million dollars a year to replace thirty FMG's with salaried staff, and the Corporation employs over fifteen hundred FMG's at this time.

Another approach would be to seek the services of National Health Service Corps doctors in our outpatient programs. The provisions of H.R. 7118 regarding the Corps would be an ideal way to bring some of the resources of that program to bear on the FMG program. In its recent consideration of the Health Manpower Act, the House Committee on Interstate and Foreign Commerce has further enhanced this concept by accepting an amendment which would allow public gen-

eral hospitals to obtain the services of Corps doctors on the same financial basis as private non-profit facilities. We urge inclusion of that provision in this subcommittee's bill.

Finally, the Corporation intends to find out which training position in its hospitals can be eliminated without ending medical services. Resistance to such reductions has been intense.

In short, while there are many approaches we can take to reduce FMG dependence, none of them are sure to produce substantial results. The Corporation believes that our best bet is to pursue all strategies at first, and rely on those which prove fruitful.

But this will take time and effort. We are committed to provide the latter, but we must look to Congress for the former. H.R. 7118 provides a grace period which the Corporation and similarly situated hospitals need to explore alternatives to FMG's. However, we feel that two years is an insufficient time in which to show a "substantial" reduction of FMG's. We agree that a strictly defined schedule for reduction is appropriate, but we suggest that a longer period of time be allowed.

Likewise, we believe that H.R. 7118 properly calls for a working plan in which each hospital must show how it hopes to reduce FMG dependence—indeed, the Health and Hospitals Corporation outlined such a plan prior to the advent of H.R. 7118—but we urge strongly that such plans, and the authorities monitoring them, acknowledge the obstacles now blocking the substantial changes necessary to eliminate FMG dependence; it would be unfortunate if hospitals felt compelled to draw up unrealistic plans so ambitious that they could not be executed in the time allowed.

Finally, while we agree that while upgrading training programs is probably the surest way to attract United States medical graduates, upgrading often implies expanding affiliations with teaching institutions. That approach can have negative effects on a hospital with strained finances and often counteracts any plans to reduce the overall number of training positions now filled by FMG's. We suggest that any Congressional action regarding FMG's make clear that a hospital may choose to improve its existing training programs without necessarily deepening its relationships with medical schools or teaching hospitals.

Aside from the points already raised, the Health and Hospitals Corporation supports H.R. 7118. Passage of such legislation will afford our hospitals time and means to reduce our present reliance on foreign medical graduates.

Thank you.

[See appendix at p. 113 for "Proposal for Reducing Reliance on Foreign Medical Graduates."]

Ms. HOLTSMAN. I would appreciate you summarizing your testimony briefly.

Mr. MANNIS. Thank you, Madam Chairwoman. I am here representing Joseph Hoffman, the president of the Health and Hospitals Corp., who asked me to express his pleasure that the subcommittee has taken the time to focus its attention on the problem of foreign medical graduates, which—I venture to say—affects the corporation as greatly as any other part of the hospital community.

The Health and Hospitals Corp. administers the 17 municipal hospitals in the city of New York. This system contains approximately 11,000 beds and provides 6 million emergency room and clinical visits each year and 3 million patient-days of care in the city of New York.

The vast bulk of the patients served come from neighborhoods where there are very few practicing physicians, very few providers of primary and health care.

Also, the vast bulk of the patients we serve are indigent and certainly are not in a position to pay in-full hospital bills or even to pay the private health insurance. Among that patient population—as you know—are a substantial number of illegal aliens for who we provide substantial amounts of health care; and the city provides many other services for that group.

An important aspect of H.R. 7118 is the requirement of hospitals to provide a working plan for gradually reducing their dependence on foreign medical graduates. Since Ms. Bellamy has summarized so well the general situation that we face in the city, I would like to speak to the possible strategies that we could use to reduce our dependence.

Somewhat before the advent of the legislation that you are considering, the corporation prepared a set of alternative strategies, knowing that it would not be appropriate to seek an extension of the time that we could obtain waivers at our hospitals if we were not prepared to discuss what steps we were willing to take, what we thought we would be able to do.

I would like to summarize those very quickly. First, it would seem that recruitment of U.S. graduates would be the best way of replacing foreign medical graduates; but I must say that given the characteristics of our hospitals, the budget constraints on us, the amenities that we offer, it's unlikely that without other changes, we would simply be able to attract U.S. graduates merely by inviting them more emphatically than we do now.

We are very interested in the possibility of placing U.S. FMG's in our hospitals, and we are looking into that, both with specific schools and relevant agencies; but it is our understanding now that doubt exists as to which, if any, of these schools are appropriate sources of personnel, particularly in preinternship programs.

So we are trying to resolve that and to be informed about that before we proceed with serious recruitment in that area.

We are very interested in the possibility of asking the State of New York to provide some kind of forgiveness program for medical students who attend school in the State, so that loans which they now obtain might be forgiven in whole or in part in exchange for service in urban, underserved areas. We are again pursuing that with the State legislature at this time.

Failing these techniques or procedures, we face the real possibility that at the end of 1980, absent any legislative change, we will be out of a great number of physicians in our hospitals and physicians who cluster in some very important areas, particularly pediatrics, in many of our institutions.

Failing anything else, we are prepared to think about hiring physicians and physician extenders to replace our FMG's and have staff medical personnel instead of trainees to provide the services.

Again, I would like to point out that the fiscal implications are substantial. We estimate that roughly due to the lesser number of hours that staff physicians serve in a week, compared to an intern, and the greater salary required to pay them, that—for example—to replace 35 FMG's with a salaried staff would cost us approximately \$1 million a year. Multiplying that times our FMG component in our hospitals, which is around 1,500, that comes to somewhere around \$42 or \$43 million of budget that we would have to find somewhere.

That is an imposing problem. If we must do that, we will; we are looking in other directions wherever possible.

One of those is the possible use of National Health Service Corps doctors, an issue which you have addressed in your legislation. We are very excited about that possibility, and we are interested in

coming up with an approach or using an approach which is suitable to the people who administer that program.

If that means restricting our eligibility for doctors by specific areas of medicine, particularly the primary care areas, we think that's a good idea.

Certainly we would want to demonstrate that our hospitals are either in medically underserved areas or serving medically underserved populations before we would consider ourselves eligible for those doctors.

I think the issue that I most want to address is the timing in H.R. 7118. We feel, frankly, that 2 years is a very short time to turn around what are very substantial problems in our hospitals, particularly the provision that calls for substantial reduction after 2 years. We agree and support the idea of a disciplining device for hospitals. I think clearly it was shown that we need it, because the last 3 years we have been relatively inactive in taking serious steps to correct this problem.

However, I would urge that the total period of adjustment be extended beyond 3 years and certainly if there is a phased reduction, that that be as much as possible moved toward the end of the period, because I think in honesty that, particularly in the area of recruitment, it will take some time to develop some real programs in that area.

So other than those conditions that I have raised, the bill that you have drafted certainly addresses all the issues that we are concerned about, both regarding FMG's and the National Health Service Corps. It's very pleasing to be able to support it with the few conditions that we mentioned.

Thank you.

Ms. HOLTZMAN. I would like to ask this question, to which any of you may respond. The Association of American Medical Colleges says that the problem of recruitment is not really a factor of a bad neighborhood or of a hospital physical plant but rather it is attributable to the quality of a particular training program. In fact, the Association of American Medical Colleges points to the fact that in some hospitals, the use of foreign medical graduates exists in high degree only in certain specialties, only in certain programs, and not in others and suggests that the difference has to do with the quality of different training programs in a particular hospital.

What is your answer to that?

Dr. DeCRESCE. I think I would like to address that. I am Robert DeCresce from the Downstate Medical School.

I think one of the problems has been, first of all, the large number of positions that are available to house officers. I know the Association of American Medical Colleges feels that a strong program should have no difficulty in recruiting people. On the face of that, it does make sense. That would be true.

Graduates of American medical schools have a tremendous number of options. You take a place like New York City, in an individual hospital. Some programs will have a large number of foreign graduates. That doesn't necessarily mean that the program is not of a high quality. It may suffer competitively compared to other programs.

For example, the closeness of its medical school affiliation; a close, medical-school-affiliated program is more desirable to medical students because they like to be around the medical school environment. A program which may offer a quality education but it is not as closely affiliated with the medical school will have more difficulty in attracting graduates.

I think also location does play some role since house officers like to live in neighborhoods where they work. Unfortunately, many of the hospitals—not just municipal hospitals—are in areas that are not as desirable to graduates of American medical schools. I think the quality issue is not one of programs that are offering poor training. I think it's a matter of other competitive factors which may be perceived by applicants as quality, closeness of affiliation, the numbers and types of physicians on the staff.

Ms. HOLTZMAN. How would you rate the quality of the training programs for most of these foreign medical graduates in New York City?

Dr. DeCRESC. I think that's a fairly general question. There are hundreds to evaluate. The programs are accredited by the accrediting organizations. They meet the standards that are set up.

Ms. HOLTZMAN. How would you evaluate them?

Dr. DeCRESC. I don't think I am in a position to evaluate the ones other than the ones I know. I evaluate some of the ones at Downstate.

I don't think the quality is of a type that is inferior. I can't judge ones I don't have direct knowledge of.

Ms. HOLTZMAN. Let me just turn to the period of time for extension of the waiver, a point about which there is some disagreement. Councilperson Bellamy, you feel 3 years would be inadequate and that a 5-year period is important. Mr. Berman, you feel a 3-year period would be appropriate. Councilperson Bellamy, perhaps we can have some further elaboration as to why you think 3 years would not be adequate?

Ms. BELLAMY. Well, I think the key really is the plan that's put in place and then some attempt to determine, through these reporting requirements, that there is some compliance with the plan; but the 2 years, with the additional time for good behavior, it seems to me inadequate. What our concern ought to be again is with the plan. The plans as they are developed, the implementation of those plans and some determination that the hospital is successfully going through a transition period.

So my emphasis, then, is allowing for adequate time and monitoring through strict reporting requirements to assure that something is being done, rather than cutting back on time and, in a sense, saying, "You better move in that time or you are going to be in trouble." I don't think it is the time period that's going to force the compliance. I think, rather, it's going to be the reporting that has the greater chance of forcing the compliance.

That's why I am urging the strict reporting requirements together with extension of the time.

Ms. HOLTZMAN. How do you feel about that, Mr. Berman?

Mr. BERMAN. I really feel if you put a signal out now that this bill is for 5 years you really do take away, I think, the type of incentive

and the type of pressure that we have seen institutions need, unfortunately. I would feel much more comfortable 3 years from now coming before you and having a list of the handful of institutions which, you know, need 1 or 2 more years, therefore, to go ahead and ask for some special extension for several institutions. But as a group, to take all institutions out for 5 years seems to be not necessary and probably not helpful to move it in the direction that the legislation some time ago was aiming for.

Ms. BELLAMY. Barry Ensminger, my counsel, would like to speak to that.

Mr. ENSMINGER. I would like to respond again. In order to obtain a waiver at all, a hospital has to demonstrate two things: One, that there is going to be a disruption of essential health services. And two, that it has not only developed a suitable plan but is complying with a suitable plan.

It seems to me you are talking about a yearly process whereby the Secretary of HHS is going to have to judge compliance before another waiver is given. So it seems to me the problem Mr. Berman alludes to can be avoided entirely by strict administrative monitoring. I think the councilwoman's testimony underscored that.

Ms. HOLTZMAN. Isn't that a question whether a plan calls for compliance within a 3-year period of time or a 5-year period of time? Surely you can monitor, but the question is do we want to reduce the dependence on foreign graduates.

Mr. MANNIS. May I repeat a suggestion I made to some of your staff a couple of weeks ago, which was that just as a schematic approach, that since one of the things that troubles us most is that we could write a plan but many of the elements are conditioned on actions of people other than ourselves, that pieces may blow up. Then, you may say, we don't have a working plan. My suggestion was that the submission of a plan occur very early, as soon as possible, and that those agencies which are going to have regulatory oversight be involved in that, work closely with us, more than just say yes or no; let us know whether it's a good plan, so that the pieces of the plan are credible to them as well as to us.

But that early on, the parameters should be laid out and the monitoring that we are talking about, and even this phased reduction of FMG's, should follow from there perhaps over a longer period of time.

Ms. HOLTZMAN. I want to ask a final question to try to put this in context. Are we talking about second-class health care? Is that what the issue is really about?

Ms. BELLAMY. Is the question are we giving second-class health care in our hospitals located in poor areas, because we are really talking about municipals and voluntaries in this case? Or are we talking about FMG's providing second-class care?

Ms. HOLTZMAN. Does the use of foreign medical graduates to the degree that we see—especially in some New York City voluntary hospitals and many of the municipal hospitals—indicate second-class health care? Isn't that the problem that we are trying to address?

Mr. ENSMINGER. I was—

Ms. BELLAMY. Let the doctor comment first.

Dr. DeCRESCE. I think the issue of second-class medicine in terms of being delivered by foreign medical graduates is one that has been addressed by a number of studies in the literature. It's never been demonstrated that in terms of on-hands taking care of patients foreign medical graduates do qualitatively something different than American graduates.

One can look at test results, and even that's in some way ambiguous, although foreign medical graduates have not been perhaps as successful on tests; in terms of studies done in actual observance of foreign medical graduates versus American medical graduates, there really hasn't been any study that definitively shows that foreign medical graduates or American medical graduates provide a superior degree of care.

Ms. BELLAMY. The study points to perhaps the ability to articulate in the English language being a greater problem than the hands-on delivery of health care. It is my view we have different levels of health care in this country. I am not sure I put the FMG problem at the top of the list as the reason for the differing level. Even in my own city there is a differing level of health care.

Your example of American doctors choosing to go into specialties rather than into primary care, rather than into family care highlights the major problem with quality INS unavailability. There are a number of other factors as well: The age of the facility, the ability to finance operations, the problems that financially troubled hospitals are having today in terms of paying for the nonpaying patients and the failure to take that into account in terms of a rational financing system. All of these, it seems to me, contribute potentially to a dual system of health care.

The FMG's may be an element of that, but I don't see it as the primary element.

Mr. BERMAN. I would like to agree that I don't believe the mere numbers of foreign medical grads occupying any training program indicates the quality of the care of the training program; but I would say that where institutions are having trouble matching, whether with foreign or with American students, it is an indication that the training program is less desirable; and to the extent that the high level of attractiveness of a training program then relates to the quality of care would get you to your issue probably a little more directly.

Ms. HOLTZMAN. But the question here is whether or not the foreign medical graduates are going to have to take a certain test. The reason that is an issue is that they can't pass the test.

There are a lot of people who say testing is irrelevant, but the fact of the matter is that is what is at stake here. I am concerned. I don't know whether it is a symptom or a cause of lack of quality in health care, but I do think we have problems with regard to testing and with regard to training in certain basic medical courses.

I do think it's a reflection of a very serious problem. While we are talking about time periods for extending the waiver, I would just like to get some sort of sense of the underlying problem in the quality of health care delivery that we really are talking about here.

Ms. BELLAMY. If I may again, I support—as I indicated in my testimony—the move toward the use of the American-trained physicians,

and perhaps what we are talking about—I merely am articulating it myself—is that we are talking about assuring the inavailability of at least some health care. I use a striking example, but it is striking considering the number of people affected. Over 90 percent of pediatric care in the borough of Brooklyn in the municipal hospitals is provided by FMG's. Where they are no longer available, but then we are talking about recruiting, and the costs of the additional personnel, what that would mean in terms of the already strained economic condition of these hospitals?

As an elected official I can say what we are talking about in some ways is no care or very little care versus some care.

Ms. HOLTZMAN. Thank you very much. My time has expired.

Before you leave, the other members may have questions. Mr. Lungren?

Mr. LUNGREN. I would just like to mention something that I didn't hear brought up. That is, the alternative plans you have when you don't have these FMG's available to you, hospitals had to go out and hire staff physicians. It has always been my impression in conversations I have had with physicians over the years—that they tended to look upon teaching hospitals that had experience and residents or the staff as hospitals that were a cut above those that were not teaching. Somehow where there's a teaching function of the hospital, along with giving care, there's a greater tendency, I think, to be concerned about the cutoff of the care, to make some judgmental values as to how you are doing against some standard, other than just going ahead.

Do you see that as a problem if you had to shift from a teaching hospital focus to a staff focus?

Mr. MANNIS. Definitely. Let me try to respond in this way: I think the alternatives that we have to reduce FMG's are sort of bracketed by two ideas that we get a lot of pressure on which are totally contradictory. One is that we should move all of our hospitals into whatever situation we can so that they resemble teaching hospitals by whatever means. The most elaborate forms of affiliation and all the responsibilities and budgetary implications that that kind of a move has for our hospitals.

That would then attract perhaps U.S. graduates to come and train. On the opposite end of the spectrum, we are under a lot of criticism for perhaps having too many trainees in our hospitals; that perhaps in certain areas they are totally unnecessary; perhaps we have too many in certain areas; and that drains our resources from providing primary care to our particular clientele which has this very heavy need for basic medical services since they have no physicians. To reduce our training program, the number of slots incurs the wrath of those people who believe in medical training as an art form.

If we try to reduce programs you can understand that it's totally contradictory to the idea of moving toward a teaching hospital model. I think if we have the resources, we would clearly want to go that way and have 17 Bellevue hospitals. Really it would be wonderful.

I think that it implies kinds of services, a certain amount of amenity that I don't believe we are in a position to do.

Mr. LUNGREN. I understand. It seems to me when you were focusing on going from teaching facilities to nonteaching facilities, you didn't talk about the implications of that beyond the costs.

Mr. MANNIS. I would defer to Dr. DeCresce, but I would say it's my understanding a lot of people feel strongly that the business of treating the poor involves primary care, providing the kind of service that the patients need and not trying to fit them into the mold of a traditional hospital patient.

So, as I say, it's definitely in conflict.

Dr. DeCresce. I would say the perception is that teaching hospitals tend to be more prestigious. Physicians like to be on the staffs of teaching hospitals. There is an appeal; and probably the teaching hospitals—and I think our experience in New York City is the major teaching hospitals and medical schools do a better job in recruiting house officers.

I think to reduce the number of training positions by replacing house officers with attending physicians doesn't necessarily dilute the quality. If the overall goal was to keep the program but cut down the size of it, I don't think that cuts down the quality.

Every hospital wants to be a medical center. That may be part of the whole problem. I don't think quality, by reducing the number of residents, is necessarily lower.

Mr. LUNGREN. In California we have a tendency to no longer call them hospitals. We call them all medical centers. It just seemed to me to coincide with the television show "Medical Center."

Thank you very much.

Ms. BELLAMY. If I may, as a comment, after 5 years of trying to re-establish financial security in our town, we are so happy to hear the health people talking about costs that I thought I would pass that along to you.

Ms. HOLTZMAN. Congressman Hall?

Mr. HALL. Ms. Bellamy, you stated that there's a surplus of physicians in the United States, I thought you said. Did you not? Here it is, page 8. It says, "Study after study has documented a nationwide surplus of physicians."

Is there a surplus of doctors in New York?

Ms. BELLAMY. Well, I always find these numbers rather distrustful. If one wants to take a look at the Bronx as one borough, one of the five counties in New York, I think they have determined there is 1 doctor per 10,000 population. I don't know where that falls in the determination of a surplus. Clearly those figures would be much smaller if one took a look at the island of Manhattan in terms of one doctor per population ratios.

I don't know that I can make an evaluation. Perhaps the people that read health studies could make a better evaluation. I don't want to mislead in my answer to you.

Mr. HALL. I was just quoting from your testimony that study after study has documented a nationwide surplus of physicians. It simply makes no sense for the United States to train more doctors than we need and simultaneously import large numbers of alien physicians.

Ms. BELLAMY. Again, I speak to that because of the history of FMG's. The amendments in 1976 were based on a belief in Congress

that we were seeing in this country a greater number of graduates of medical schools, and—therefore—it would no longer be necessary to encourage the immigration of FMG's.

Therefore, the immigration restrictions were imposed with the phased-in period allowed. That's what I am referring to in talking about the determination of a nationwide surplus.

Mr. HALL. How many medical schools do you have in New York State? How many graduates do you usually have each year in New York State?

Third, where do they go to when they graduate?

Ms. BELLAMY. May I ask Mr. Berman to try to respond? I am sorry to shift that over. I don't have the information.

Mr. BERMAN. I don't have the numbers.

Dr. DeCRESCE. I can comment on New York City. There are 1,200 graduates, 8 medical schools in New York City. These 1,200 people graduate from those schools per year, about 8 percent of the Nation's doctors. About 50 percent stay in New York for their training and 50 percent leave New York.

About half stay in New York City of the doctors who graduate from medical school.

Mr. HALL. Do they stay in the State or go out in the other areas of the country?

Dr. DeCRESCE. I assume they go out to other areas of the country.

Mr. BERMAN. It is both.

Mr. HALL. What you are concerned about primarily is that, as is indicated in the testimony of Mr. Mannis, at the end of this year, existing provisions of the act prohibit entry of all but a few foreign medical students. What you attempt to do is to impress upon that an extension of maybe 3 to 5 years before that termination date occurs?

Ms. BELLAMY. Yes; that is what we are supporting. We have some differences on the time.

Mr. HALL. I understand.

Ms. BELLAMY. You managed to do what others haven't in the city and the State, actually agree on something here.

Mr. HALL. Do you have any studies as to how the rest of the country, other than New York City, might react to this bill? You know, there is another portion of it extending all out to the west coast and down to the Rio Grande.

Do you have any facts and figures on how the rest of the world might react to this bill?

Mr. MANNIS. Well, Congressman, we had some numbers that were gathered. This is a couple of years ago, 3 years ago. Is Michigan on the Rio Grande? We definitely—

Mr. HALL. You say is Michigan on the Rio Grande? If that's all you know about this country—

[Laughter.]

Mr. HALL. I am jesting, of course.

Mr. MANNIS. Because in part we are from the city, we always assume our problems are the biggest and so forth. When we came to look at what numbers were available regarding distribution of FMG's in the country, we found that while there was not—clearly not a

nationwide distribution, there was substantial distribution of FMG's in the Northeast, including—well, the States that I—let me just, if I may, read these, the States and the total dependence on FMG's. This would be percentage of all house officers in 1977. The State of Connecticut, 73 percent; New Jersey, 58 percent; New York, 41; Illinois, 41; Delaware, 40; down Maryland, Michigan, the State of Ohio, 28 percent.

So clearly it is a regional problem, but it seemed also clear to us that it was not one focused in the city of New York.

Mr. HALL. It was mentioned here today about the quality of care. The experience I have had with foreign medical graduates has been very, very good. Of course, I come from an area in the Southwest where there's a shortage of physicians. There's not a day goes by or week goes by that I don't have some communication from a hospital in areas requesting help in getting foreign graduates, foreign physicians into that area.

When they come, they are excellent doctors. I gage that by what you hear from medical personnel, staff privileges, and all those things, that they acquire after being here a certain period of time.

So I am not in favor of prohibiting all foreign medical students or foreign medical graduates, but I don't know how the provisions of this 7118 will be received nationwide. I can see the problem that you have in New York City and in the State of New York.

Ms. BELLAMY. Again I would point out, so you have it on the record, my testimony on pages 4 and 5 speaks to the various percentages that Mr. Mannis just read you from Illinois to Michigan to Ohio, Maryland, New York, Connecticut, and New Jersey.

We obviously can speak best to our own areas of knowledge; but point out that this is not a problem inherently confronting just those of us who are in New York.

Mr. HALL. Thank you.

Ms. HOLTZMAN. I will recognize myself briefly to respond to the remarks of the gentleman from Texas. Not only has similar legislation been passed by another subcommittee of the Congress, but the administration has testified in favor of it. This is a problem that has an impact beyond one city. I should say the chairman of the full committee has a serious problem in his district in Newark in New Jersey.

The second bells have rung. We will adjourn, but I would like to thank again the panel for the extremely valuable testimony, particularly Mr. Berman and the very distinguished and able city councilperson.

Ms. BELLAMY. Thank you.

Mr. BERMAN. Thank you.

Ms. HOLTZMAN. The subcommittee will adjourn for 10 minutes.
[Recess.]

Ms. HOLTZMAN. The subcommittee will resume the hearing.

We will hear from the final panel of witnesses consisting of, first, the Association of American Medical Colleges, represented by Jack T. Myers; second, the Educational Commission for Foreign Medical Graduates, represented by Ray L. Casterline; and the American Medical Association, represented by Leonard Fenninger.

TESTIMONY OF JACK D. MYERS, PROFESSOR (MEDICINE), UNIVERSITY OF PITTSBURGH, ON BEHALF OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES; RAY L. CASTERLINE, EXECUTIVE DIRECTOR, ON BEHALF OF THE EDUCATIONAL COMMISSION FOR FOREIGN MEDICAL GRADUATES; AND LEONARD FENNINGER, GROUP VICE PRESIDENT FOR MEDICAL EDUCATION, ON BEHALF OF THE AMERICAN MEDICAL ASSOCIATION

Ms. HOLTZMAN. Thank you very much for coming before the subcommittee. The Chair has to be in a meeting at the White House very soon. I would ask the indulgence of the witnesses, please, to summarize the testimony within about 3 minutes apiece, and then we will have time for some questions.

Without objection, the text of each of your statements will be included in the record.

We will begin with Dr. Myers.

Dr. MYERS. Madam Chairwoman, I appreciate this opportunity. I will try to be very brief. The first comment I want to make has to do with the extension of the training period. This has been discussed by other witnesses. The AAMC is strongly in favor of this and feels this should be extended to the full amount of specialty plus in some instances subspecialty training that the foreign medical graduate should receive in this country.

We recommend actually that your bill spell this out in regard to the full extent of specialty and in some instances subspecialty training.

The second point has to do with the elimination of the specialty board certification as a requirement for waiver of the VQE. We don't feel strongly about this one way or the other. It's a "one-shot" deal and would perhaps help that one class of foreign medical graduate.

We would hope it wouldn't be a precedent, however, for future exemptions to be made.

The point on which we feel, I think, most strongly has to do with the VQE waiver for the J visa for incoming medical graduates. There we are against the provision in the bill. The AAMC has always been in strong support of the VQE examination and we feel that it is a good check on the quality of the incoming foreign medical graduate to profit and reasonably participate in our U.S. educational system.

We emphasized that 95 percent or more of U.S. medical graduates can pass the equivalent of this examination, and we can see no reason why the foreign medical graduate shouldn't be equivalent in preparation, coming into the same type of residency training program.

We are looking at residency programs primarily as educational experiences and secondarily as programs which provide, of course, health care in the progress of the educational experience.

We have further concern in regard to problems like that of New York City; that unless high quality residents do get into a program, since they teach one another a great deal, and where medical schools are involved, they also are involved in the teaching of medical students; but you can't build a quality program that in due time is going

to attract U.S. medical graduates unless those foreign medical graduates who are in the program are really capable individuals.

If they are second rate, then the program is not going to be attractive to U.S. graduates who by and large do choose their programs in graduate medical education on the basis of quality. I would emphasize that particular point.

We have been disappointed in the last 4 years since the legislation was passed that many institutions have made no progress in improving the attractiveness of their graduate medical educational programs to U.S. medical graduates.

This gets into the subject of how much additional time, if any, should these programs have as has been discussed by many witnesses here today, to allow a transfer from emphasis on foreign medical graduates to U.S. medical graduates.

From the poor past record and from the fact that in talking to some of these persons we have not been impressed that any good plans exist for this transition, we have reservations about the prognosis on this issue and would oppose any extension of not having the VQE as a requirement for a J visa.

The last issue I want to comment on has to do with the substantial disruption waiver and declaring such areas health manpower shortage areas.

We have no objection to this at all. Then there are two ways the bill provides that this be implemented: That the physicians in the—I lost my terminology here—in the National Health Service Corps—the physicians in the National Health Service Corps—that either serve in these institutions which are declared shortage areas as residents or as what I call staff physicians.

We favor them serving or being able to serve as staff physicians, but would oppose their serving in these areas as residents.

In the first place, the National Health Service Corps wasn't set up for this purpose. It could be changed for that purpose; but residency is a very important part of overall medical education and to a great degree I can say, as a medical educator, that the career of the young man or woman in medicine is determined by the experiences of the residency period.

I would hate to see any coercion or other pressure—and there would be fiscal pressures in this plan, because they do get time off, so to speak, for the years spent as a resident—influencing the career and perhaps damaging or altering the career of an otherwise very good person.

So we would be most willing to have the National Health Service Corps physicians serve as staff physicians, to replace FMG's in these instances—

Ms. HOLIZMAN. Dr. Meyers, I must interrupt you at this point.

Dr. MYERS. I was just finishing.

[The complete statement follows:]

STATEMENT OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, PRESENTED BY JACK D. MYERS, M.D.

Madam Chairwoman and members of the subcommittee: The Association of American Medical Colleges is pleased to have this opportunity to comment upon H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens to graduate medical education training programs.

The Association is the national voice for all of the 126 operational U.S. medical schools and their students, more than 400 teaching hospitals and over 60 academic and professional societies whose members are engaged in teaching, research, and patient care. The Association, through its constituents, has a fundamental interest in the system of graduate medical education in the United States; thus its keen concern about H.R. 7118 and its impact upon the quality of graduate medical training.

The provisions proposed in this legislation relate to foreign medical graduates (FMG's) in, or coming into, the United States for graduate medical education under the student exchange (J-Visa) provisions of the Immigration and Nationality Act (INA), and include, as you well know, the following:

The permissible duration of the training program would be extended to the time necessary to permit an alien to complete a training program in a given specialty or subspecialty.

One of the exceptional conditions under which the Visa Qualifying Exam (VQE) requirements can now be waived for either an exchange visitor or permanent immigrant is modified. The present law exempts those FMG's who, as of January 9, 1977, were: Fully and permanently licensed by a state, and certified by an ABMS specialty discipline, and engaged in medical practice in a state.

This proposal eliminates the second of these requirements—that for board certification.

The requirement to pass the VQE as a condition for receiving a J-Visa would be waivable until December 31, 1982, if the Secretary of Health and Human Services (the "Secretary") were to determine on a case-by-case basis that its imposition would substantially disrupt the health and medical services provided by the hospitals in which the graduate medical education of these physicians is taking, or was to take, place. An additional one-year extension, until December 31, 1983, could be granted if the Secretary were to find that a program had substantially reduced its reliance on alien graduates of foreign medical schools. In order for a program to be eligible for a waiver of the VQE requirement, it would have to submit a detailed discussion of the problems anticipated without such a waiver and the alternatives that had been considered to reduce such disruption. The Secretary would also have to receive a description of the efforts that had been or would be made: to use alternative resources (including physician extenders), to improve the graduate medical education offered and to recruit resident physicians who are U.S. citizens. Finally, a comprehensive plan, on a year-by-year basis, would have to be submitted, detailing the way in which the program intended to reduce its dependency upon alien FMG's.

The definition of a health manpower shortage area would be amended to include hospitals which have received a substantial disruption waiver within the last 12 months. This statutory redefinition would have the effect of making such hospitals appropriate sites for the assignment of physicians who had held National Health Service Corps (NHSC) scholarships while in medical school. Whenever possible, Corps personnel would be assigned to these shortage areas to reduce the number of FMG's in residency training programs. An institution would be required to reimburse the Federal government not for the entire amount of an assigned Corps member's salary, but only an amount equivalent to the stipend it would have paid an alien resident.

Physicians who had held NHSC scholarships would be permitted to credit the time spent in these hospitals in the status of graduate medical education students (Interns and residents) toward the service payment obligation in their scholarship agreements.

EXTENSION OF TRAINING PERIOD PERMITTED UNDER THE J-VISA

Of the provisions concerning FMG's in H.R. 7118, the one to permit an extension of the period of training has been the most widely discussed and is the least controversial. A similar provision is contained in S. 2378, a bill introduced by Senator Jacob Javits, and in H.R. 7204, a bill introduced by Representative Henry Waxman and recently marked-up by the House Committee on Interstate and Foreign Commerce. Currently, FMG's who have passed the VQE may come to the United States for graduate medical education for a period of two years, with extension for a third year contingent upon approval from the visitor's home government. This arrangement does not give resident physicians adequate time to meet eligibility requirements of many of the medical specialty certifying boards

of the American Board of Medical Specialists (ABMS), requirements that may be assumed to reflect the necessary period of training for a designated specialty. Under the current law, the VQE and language requirements assure the competence of the alien graduate medical education students. Thus, there would seem to be little reason to limit the participation of such qualified aliens in U.S. education programs, provided of course that they could be accommodated locally. This country has had a long tradition of welcoming exchange students, and U.S. educational institutions point with pride to the achievements of alumni who attain distinction in their country of origin.

If graduate medical education programs accept alien physicians, there is little reason to truncate tenure prematurely, i.e., before the training program has been completed. The only real objection is that the longer training period gives the exchange visitor a longer exposure to the "hazard" of acquiring an American spouse, and, therefore, American citizenship. By and large, however, extension is in the best interest of the individual, the program, the individual's country of origin, and the U.S.; on that basis the Association supports the proposal to amend Section 212(j)(1)(D) as drafted in H.R. 7118. However, the Association urges the Subcommittee to consider amending this provision to provide, as do S. 2378 and H.R. 7204, that the duration of an alien graduate medical education student's stay be limited to the lesser of seven years or the time typically required to complete such a program. It would also be reassuring if the bill indicated that the criteria to be used by the Director of the International Communication Agency were required to be consonant with the specialty board requirements established by the member organizations of the ABMS. Such changes to the provision in H.R. 7118 would serve to limit any possible abuse of it.

VQE WAIVER UNDER EXCEPTIONAL CIRCUMSTANCES

The significance of the proposal in H.R. 7118 to further relax the circumstances under which the VQE requirement can be waived for exchange visitors or permanent immigrants who were licensed by and practicing in a state prior to January 7, 1977 is not clear to the AAMC. In principle, the Association strongly supports the VQE screen to protect the American public from encounters with alien physicians whose education is not up to U.S. standards. The proposal would appear to have a limited impact, to involve a relatively small number of individuals and to be non-recurrent. Without clarification of the intent, meaning and significance of this amendment, the AAMC is unable to determine whether it represents a reasonable and just accommodation in behalf of individuals caught in a period of transition or a serious violation of an important principle.

EXTENSION OF VQE WAIVER UNTIL DECEMBER 31, 1982

One of the most significant changes to the INA wrought by Public Law 94-484 was the institution of a requirement that J-Visa holders pass the VQE. The purpose of this modification by the Congress in 1976 was to raise the educational achievement standards for FMG entry into the U.S. for graduate medical education, and thereby to protect the American public from contact with inadequately educated physicians serving as hospital residents. The current statute requires that, as of January 1, 1981, all FMG's coming to the U.S. for training will have passed the VQE; until then, institutions can file for a waiver of this VQE requirement, on the ground that there would be "substantial disruption" of medical service if FMG's on the staff of an institution were required to have passed this examination.

The AAMC recognizes that a few hospitals in this country, particularly in areas such as New York City, are faced with severe problems in recruiting U.S. medical graduates for their residency programs. Nonetheless, the issue is no different today than it was when Public Law 94-484 was passed in October, 1976. I "substantial disruption" waivers are continually granted, these hospitals which have had four years to correct their deficiencies will postpone confronting the real problem—the quality of the graduate medical education offered and the consequent inability of the program to attract graduates of U.S. medical schools. The AAMC does not take pleasure in appearing to be unsympathetic to the needs of these distressed hospitals. But it is equally distressed by the fact that a substantial segment of the least advantaged American citizens, who live in the affected areas and who depend on these hospitals almost exclusively for their medical care, must rely on physicians who cannot pass

an examination so designed that 95 percent of U.S. medical graduates would be expected to pass. Current practices—apparently little different than those prevailing before the enactment of Public Law 94-484—are not a socially acceptable, let alone an ideal, solution to even the medical care aspect of this problem.

The proposal to extend the substantial disruption waiver process implies that the purpose of a residency program is to provide service, ignoring the fact that the fundamental *raison d'être* of a residency program is educational. Residents are important participants in the American system of medical education. They both receive education from more senior residents and from fully trained attending faculty physicians while, at the same time, they assist in the training of more junior house staff and, depending on the nature of the hospital's affiliation with a medical school, medical students. The solution offered by the use of waivers would undermine the quality of education offered and ultimately worsen the very problem it is designed to address. Medical school graduates applying for residency positions are primarily concerned about the quality of education and training offered by a given program. The presence of poorly trained upper-level residents can only serve to lower the quality of a program and thus its attractiveness to the graduates of U.S. medical schools.

In the course of their education, residents, by participating in patient care under supervision, do contribute to an institution's provision of care to those whom it serves. However, because education is primary the Association must regard this as an education, not a health care, issue. In this context, it is persuaded that, if the directors of those graduate medical education programs and the medical schools with which they are affiliated were forced to focus attention on the quality of the training programs, the dependence of these programs on FMG's would rapidly diminish.

The Association does not recognize that the provision in H.R. 7118 to extend the waiver process is a modest improvement over like provisions in other legislation recently introduced in Congress (i.e., H.R. 7204 and H.R. 6800 which would permit waivers through the end of 1983, and S. 2378 which would do so through 1985) in that it limits the general availability of the waiver to an additional two year period and requires that before a substantial disruption waiver may be issued, the institution must have a fairly detailed plan for reducing its dependency on alien FMG's. However, in implementing the current law, institutions have already been required to formulate such a plan and this requirement has apparently not been successful in resolving the problem; therefore, the Association does not believe that the change incorporated in H.R. 7118 is of sufficient substance to permit support of the provision.

DESIGNATION OF SELECTED HOSPITALS AS HEALTH MANPOWER SHORTAGE AREAS

The root causes of the difficulties encountered by public urban hospitals in attracting sufficient numbers of residents lie in the serious social problems of poverty and the economic decline of many of our cities. The long-term solutions to these problems are not within the capacity of the hospitals to solve. They must, however, try to deal, in the short term, as competently and humanely as possible with the enormous problems of disease and disability facing them each day. Steps to improve the financial health of these institutions would contribute importantly to solving the problem of attracting qualified physicians to participate in residency training programs. There are, however, actions which can be taken to address directly the problems facing public hospitals because of recently stiffened immigration laws. A short-term solution is offered by the provision in H.R. 7118 for the use of National Health Service Corps physicians to fulfill their service obligations by serving as faculty or staff in such hospitals. As in the case of extending the substantial disruption waiver mechanism, no additional expenditure of Federal money would be required, but unlike that alternate solution, medical services would be provided by individuals whose competency in language and medicine is not in doubt. H.R. 7118 would permit any hospital which receives a substantial disruption waiver to be considered a shortage area (as defined in Section 332 of the Public Health Service Act).

While the association is opposed to the continuation of the substantial disruption waiver provision, it views as an appropriate means of defining a shortage area for this purpose a provision of the sort contained in S. 2378, the Bill introduced by Senator Jacob Javits, which proposes that certain hospitals be

designated as health manpower shortage areas if more than a given percentage of their resident staff is composed of FMG's. The exact magnitude of dependence on FMG's necessary to permit such a designation might be left to the Secretary to define through appropriate regulations.

While providing that these institutions may be eligible for assignment of NHSC scholarship recipients has attractive features, it also may cause some new fiscal problems in a situation where the basic problem is overwhelmingly fiscal. The Association has no quarrel with the requirement that the assignment of Corps members in a hospital should, whenever possible, reduce the number of alien FMG's in residency training programs in that institution. However, it must be borne in mind that the status of Corps members is not the same as that of alien resident physicians. Members of the Corps are fully trained physicians who have already completed residency training; members of the Corps would probably be reluctant to once again invest the long hours typically spent by resident physicians in their first years of graduate medical training to extract the maximum benefit from the educational opportunities derivable from participation in residency training programs. Thus, even though a fully-trained NHSC member may be more productive than a resident physician, the round-the-clock medical staff coverage that must be available in hospitals could not be met by a one-for-one substitution.

In order to hire additional staff to make up for the fact that one Corps member would not be sufficient to deliver the health services regularly provided by a single house staff physician, the hospital will have to find additional sources of funds—a very difficult to unlikely prospect in light of the dire financial condition of many of these hospitals, and made even more difficult by the requirement that the institution would have to reimburse the Federal government for each Corps member assigned to it an amount which is equivalent to the stipend it would have paid an alien resident. It is hard to imagine how a hospital could solve the problem of upgrading or rebuilding its residency programs when it would have to spend down its resources for that activity in order to subsidize the problem's short term solution—the use of Corps physicians. The Association, therefore, recommends that the hospitals be released of any obligation to repay for services provided by NHSC physicians and that placement of NHSC physicians in such institutions be made on a case-by-case basis by inquiry into the actual needs of the hospitals rather than by use of an arbitrary formula of one-NHSC M.D. added for one-alien FMG position removed. Otherwise many may never be able to engage in quality graduate education and may become permanently dependent upon the NHSC.

FULFILLMENT OF NHSC OBLIGATION THROUGH PARTICIPATION IN DESIGNATED RESIDENCY TRAINING PROGRAMS

While the AAMC supports designating hospitals with a significant dependence on FMG's as health manpower shortage areas for the purpose of having NHSC volunteers assigned to them, it must oppose the award of service pay-back credit to residents for the period of graduate medical education received in these hospitals. A review of the legislative history of the National Health Service Corps indicates that this program was designed to provide fully trained and qualified physicians to deliver medical care to the underserved populations of this country. Residents are not fully trained; in fact, they are trainees. To allow them to accrue pay-back credit while still in student status contravenes the original, and still valid, intent of the Congress. Section 752b5(A) of the PHS Act very clearly states: "No such period of internship, residency or other advanced clinical training shall be counted toward satisfying a period of obligated service" for NHSC. Again, it must be reiterated that the fundamental purpose of residency programs is to provide further education to medical school graduates and not to provide medical service—the NHSC program is one whose reason for existence is the provision of health care services and not medical training.

CONCLUSION

Over the long-term the real solution to the health service delivery problems resulting from the changes in immigration laws is the improvement of the quality of graduate medical education offered by these public general hospitals. In a study sponsored by the Human Resources Administration of the Department of Health, Education, and Welfare,¹ improvement of the quality of medical training

¹ Identification of Special Efforts of Title VI Restrictions on Selected Hospitals and Implications for Health Manpower. Urban Systems Research Engineering, Inc.

programs was one of the few proposed solutions that was considered to address adequately the potential manpower problems due to restrictions on entrance of FMG's into the United States contained in the 1976 law. Comparisons of recruitment results in different specialty residency programs in the same hospital show the correctness of this assertion: some residency programs in some specialties have been able to recruit U.S. medical graduates while others in that identical institution continue to attract few. The fact that differences in recruitment results are observed in the same hospital suggests that they are not attributable to hospital physical plant, to socioeconomic characteristics of patient population, to neighborhood area or to type of hospital ownership, but reflect the commitments of individual clinical departments to innovative leadership, improved staffing and a heightened educational emphasis. These factors appear to be the critical variables which effect the program's attractiveness.

The Association is willing to work with the schools to assist them in anyway it can in an effort to improve their graduate medical education programs. However solutions of this character may well require substantial financial assistance to defray the additional costs of hiring new faculty at all levels, of providing better support services such as laboratory services and of expending in-house educational programs.

Ms. HOLTZMAN. Thank you very much.

The next witness is Ray Casterline who represents the Educational Commission for Foreign Medical Graduates. Without objection, your testimony will be incorporated in the record. You may proceed very briefly, please.

Dr. CASTERLINE. I appreciate this opportunity to appear before you to discuss these various provisions of H.R. 7118 with respect to the admission of certain aliens for graduate medical education.

The points I would like to emphasize briefly relate to comments made earlier today, in particular the reason, as I see it, why the number of requests for waiver is increasing, whereas, as the years go on, you thought there would be a reduced number.

During this period since 1970, 29 programs requested 35 waived positions; 19 were approved. In 1979, 34 programs requested 140 waived positions; 108 were approved. During the first 4 months of 1980, 35 programs requested a total of 206 positions; 187 have been approved.

In my opinion this increase is a matter of efficiency in the provision of medical care. Senior residents, most of whom were here at the time the Public Law 94-484 became effective, are much more effective in the provision of health care, medical care services. A fourth-year resident can provide considerable care. A first-year resident provides a much smaller amount of care per hour, much less service for training.

Thus, as I see it—and as I predicted at the beginning of the waiver program—this would happen because of the need for increased numbers to make up for the senior residents who were leaving programs because they had completed them.

Therefore, the increased duration of the waiver provisions would seem to be required to allow a catchup in this if the increased duration of stay of the individual is to be allowed.

Second, I think that you should—the committee should be aware of the numbers of individuals who are available in the pool upon which this country can draw, as it were, for individuals who are qualified under the provisions of the Public Law 94-484 examination and other areas; particularly the VQE.

Of the 12,618 who took the examination, and the 3,545 who passed the VQE in the 3 years 1977-79, only 3,245 actually are eligible for admission to a training program in the United States as well as obtaining a visa to enter.

That is a substantially lower number than were admitted in earlier years. I think it's something that the committee should consider seriously in their deliberations.

From our perspective, extension of the waiver through December 1983 would not increase the exchange visitor numbers to the point of running contrary to the point of the law nor would it result in exceeding the January 1980 cap imposed by the Congress.

It would give areas such as New York a more realistic time to phase down reliance on alien positions.

Ms. HOLTZMAN. I am going to have to warn you. I will let you testify 1 more minute.

Dr. CASTERLINE. It would allow for a large number of people to be available to fill in the gap.

Ms. HOLTZMAN. Thank you. Please accept my apologies for this. I couldn't foresee this this morning.

[The complete statement follows:]

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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May 9, 1980

The Honorable Elizabeth Holtzman
 Chairwoman, Subcommittee on Immigration, Refugees, and
 International Law
 Committee on the Judiciary
 United States House of Representatives
 Rayburn Office Building
 Washington, D.C., 20515

Dear Chairwoman Holtzman:

The Educational Commission for Foreign Medical Graduates (ECFMG) has been asked to comment on certain provisions of a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate education or training programs (H.R. 7118).

I am submitting a statement that addresses the following provisions of H.R. 7118:

1. Deletion of "specialty certification" from the provisions of the August 1, 1977 (Public Law 95-83) amendment to the Immigration and Nationality Act. This would allow an alien physician to be considered to have passed the Part I and Part II examinations of the National Board of Medical Examiners if he was:
 - a. on January 9, 1977, a doctor of medicine fully and permanently licensed in a State; and was
 - b. on that date practicing medicine in a State.
2. Increase in the duration of stay of Exchange Visitor Foreign Medical Graduates (EVFMGs) in accredited graduate medical education training programs in this country to allow them to complete their training objectives;
3. Permission for EVFMGs to make one change in their training objectives not later than 2 years after they begin authorized training;
4. Extension through December 31, 1983 of the "substantial disruption waiver" provisions of the Health Professions Educational Assistance Act of 1976 (PL 94-84); and
5. Evaluation of the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools.

I appreciate this opportunity to appear before the subcommittee and to discuss the provisions cited above from the vantage point of the Educational Commission for Foreign Medical Graduates.

Respectfully submitted,

Roy L. Casterline, M.D.
 Executive Director

RLC:vdv

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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May 14, 1980

Statement on H.R. 7118 by Ray L. Casterline, M.D., Executive Director,
Educational Commission for Foreign Medical Graduates

Madam Chairwoman and members of the subcommittee, I appreciate this opportunity to appear before you to discuss certain provisions of a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs (H.R. 7118). This statement will address the proposed deletion of "specialty certification" as one of the requirements for alien physicians to meet, if they were in the United States, licensed to practice medicine, and in practice in a State on January 9, 1977, and wished to be considered to have passed the National Board of Medical Examiners Part I and Part II examinations; the proposed increase in the duration of stay of Exchange Visitor Foreign Medical Graduates (EVFMGs) in accredited programs of graduate medical education or training; the proposal to permit EVFMGs to make one change in their training objective; the substantial disruption waiver provisions of the Health Professions Educational Assistance Act of 1976 (Public Law 94-484) and the extension of those provisions proposed in H.R. 7118; and the proposal to evaluate the effectiveness and value to foreign nations and to the United States of exchange programs for the graduate medical education or training of aliens who are graduates of foreign medical schools.

The Educational Commission for Foreign Medical Graduates (ECFMG) is a separate nonprofit organization that is sponsored by seven of the leading organizations in the field of medical education and health care in the United States.

In recognition and fulfillment of their public responsibilities for health care and education, the sponsoring organizations established ECFMG to concern itself with foreign medical graduates.

To meet its responsibilities, ECFMG identifies the following as its aims and missions:

- (1) To provide information to foreign medical graduates regarding entry into graduate medical education and health care systems in the United States;
- (2) To evaluate their qualifications for such entry;
- (3) To identify foreign medical graduates' cultural and professional needs;
- (4) To assist in the establishment of educational policies and programs to meet the above-identified cultural and professional needs of foreign medical graduates.

- (5) To gather, maintain, and disseminate data concerning foreign medical graduates; and
- (6) To assist, through cooperation and recommendation, other agencies concerned with foreign medical graduates.

During the past two decades, ECFMG has become most widely known for its examination and certification program. ECFMG certification is a requirement to enter accredited graduate medical education training programs in the United States and facilitates obtaining a license to practice medicine in most of the states in the United States. In addition, ECFMG administers the Visa Qualifying Examination (VQE). Passing the ECFMG English test is not only a prerequisite for ECFMG certification but also to take the VQE.

Pertinent to this discussion, however, is ECFMG's role as a sponsor of an Exchange Visitor Program for alien physicians who enter the United States to participate in accredited programs of graduate medical education or training. The International Communication Agency provides ECFMG authority to serve as a sponsor and to issue the documentation (Form IAP-66) required as one of the prerequisites for an alien physician to obtain a J-1 (Exchange Visitor) visa to enter the United States.

At least four provisions of H.R.7118 relate to the graduate medical education of alien physicians who have entered, or will enter the United States as Exchange Visitors under the sponsorship of ECFMG. Each of those provisions will be discussed separately.

SPECIALTY CERTIFICATION

The Educational Commission for Foreign Medical Graduates is not directly involved in the process of licensure to practice medicine in the United States. Nonetheless, I believe that it is important to delete "specialty certification" from the provisions of the Public Law 95-83 amendments to the Immigration and Nationality Act. Specialty certification has little to do with licensure to practice medicine in the United States.

INCREASED DURATION OF STAY

ECFMG is aware of concern regarding the three-year maximum limitation of stay for Exchange Visitor alien physicians. The concern has been expressed by government officials as well as by leaders in the medical profession of various foreign countries. This restrictive provision of the law has disrupted many traditional programs of international exchange in graduate medical education between medical schools in Latin America and institutions in the southeastern United States. Physicians from Venezuela, in particular, have expressed concern regarding the hazards that will result if young Latin American physicians are forced to receive training in the Soviet Union and other countries where Marxist attitudes prevail. The restrictive provision has also caused comparable interference with similar programs between institutions in the United States and those in the United Kingdom, Italy, Egypt, Saudi Arabia, Australia and New Zealand. Of interest is that schools in countries which provide medical education comparable to that offered in the United States are also most concerned about the restricted

length of stay. From meetings with various officials and medical leaders, I believe there is a consensus that the current permissible length of stay poses problems and that the problems are primarily educational relating to the inability of trainees interested in high quality graduate medical education to remain for a sufficient period of time to obtain the education they require.

From the ECFMG perspective, the ECFMG Board of Trustees supports increasing the duration of stay to allow completion of a training objective and maintains that such an increase would not jeopardize the intent of the law nor would it result in exacerbation of the classic brain-drain syndrome.

As you are aware, one of the recent amendments to PL 94-484 requires that exchange visitor alien physicians must make a commitment to return to their home country upon completion of training in the United States. This requirement, in addition to the controls ECFMG has over the issuance of the form (IAP-66), which allows exchange visitors to obtain a J-1 visa, would preclude the exchange visitor from remaining in this country indefinitely.

Consequently, increasing the duration of stay would 1) do much to enhance our international relations with many countries who value the training that the United States has to offer and 2) would benefit hospitals which are currently depending upon the substantial disruption waiver provision of the law to carry them through the transition period.

PERMISSION TO CHANGE TRAINING OBJECTIVE

Most alien physicians who enter the United States as Exchange Visitor Foreign Medical Graduates adhere to their initial training objective (chosen specialty), complete it and return home. Some trainees (and some countries) learn that the initial objective is not appropriate. This can occur for a wide variety of reasons, i.e. inadequate prior knowledge regarding the scope of medical specialties in the United States, reevaluation or self-assessment of the alien physicians particular talents, etc. At present, the three-year maximum stay for Exchange Visitors, discourages alien physicians from making what could be appropriate changes in their training objectives. Presently, if the exchange visitor were to make a change, the three year limit would not provide enough time for a valid educational experience.

If the duration of stay for Exchange Visitors is increased, the ECFMG Board of Trustees supports limiting alien physician EVFMCs to only one change of objective and that change should take place no later than the end of the second year of participation in the Exchange Visitor program.

As you are aware amendments to PL 94-484 require that an alien physician who enters the United States as an Exchange Visitor must provide a letter from his home country government stipulating that there is a need in that country for physicians with the type of training that the alien is seeking. Furthermore, the home country government must also certify that the alien has filed a written assurance with the government of his country that he will return upon completion

of training in the United States and intends to enter the practice of medicine in the specialty for which the training is being sought. In addition, under the Memorandum of Understanding between the International Communication Agency and ECFMG, the alien trainee is permitted to make one change in his training objective, but only with the agreement of his home country government.

With such caveats, alien physicians' changes in their training objectives should not contribute to abuse of the Exchange Visitor Program. More positively, it will allow those alien physicians and countries depending upon the United States for graduate medical education an opportunity to select the most appropriate training.

WAIVER PROVISION EXTENSION

Amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing Exchange Visitor (J-1) Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training.

In brief, these requirements are

- (A) an accredited school of medicine, or any one or more of its affiliated hospitals, must agree in writing to provide or assume responsibility for the graduate medical education or training;

- (B) the alien physician must pass the Visa Qualifying Examination (VQE), must demonstrate competency in oral and written English, must be able to adapt to the educational and cultural environment in which he will be receiving his training, and must have adequate prior education for successful participation in the program;
- (C) the alien must make a commitment to return to his home country upon completion of training in the United States, and his country must provide written assurance that there is need for the alien's services in his country; and
- (D) the alien will be allowed to stay in this country no more than 2 years, unless additional time is specifically requested by his country for a maximum of one additional year. The extension is for the purpose of continuing the alien's education or training under the specific program for which he or she came to the United States.

The stated intent of these amendments was to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs in the United States.

The intent has come to fruition insofar as there has been a decrease in numbers of exchange visitor foreign medical graduates. On January 10, 1977 ECFMG sponsored 5,090 exchange visitors. To date ECFMG is currently sponsoring 2,000 exchange visitors. As you can see this represents a substantial reduction on numbers of exchange visitors.

Since the Congress anticipated this severe reduction they provided for waiver of two of the requirements on a case-by-case basis, if a graduate medical education program could demonstrate that application of these requirements would result in a "substantial disruption" of health services.

Under the substantial disruption waiver, an Exchange Visitor Foreign Medical Graduate (EVFMG) is not required to:

1. have an accredited school of medicine, or any one or more of its affiliated hospitals provide the graduate medical education; and
2. pass the Visa Qualifying Examination.

The substantial disruption waiver was designed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

To put the waiver mechanism into effect, the Department of Health, Education, and Welfare (HEW) developed: 1) eligibility criteria to identify programs and institutions affected by these provisions and 2) decreasing numerical limits to permit programs and institutions a gradual rate of phase out for dependency on alien physicians while developing alternative provider resources.

The design of the waiver mechanism provides for two tiers of waiver application. Tier I is for programs and institutions which meet the eligibility criteria and are requesting waivers within the numerical limitations. Tier II is for programs and institutions which:

- 1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or
- 2) do not meet the eligibility criteria

ECFMG is the receipt point for Tier I applications, and reviews and processes the applications under the established numerical limits.

Tier II appeal applications are also mailed to ECFMG for initial processing. ECFMG forwards appeal applications to the Health Resources Administration of the Department of Health, Education, and Welfare for consideration. A Federal Substantial Disruption Waiver Appeal Board consisting of seven Federal members has been established to review these applications. The appeal board determines whether programs qualify for additional waivers.

Length of Validity for Waived J-1 Visa Holders

An individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for two years, and for one additional year, if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of Exchange Visitor Sponsorship (IAP-66). Also, waived J-1 visa holders must be counted in determining the program's eligibility for future waivers.

Since waivers are assigned to programs and/or institutions, individual EVFMGs cannot transfer from waived positions to non-waived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa (Exchange Visitor) status.

Also, an alien physician entering under a substantial disruption waiver must hold ECFMG certification.

Statistics

During a seven month period in 1978, 20 programs requested a total of 35 waived positions. Nineteen (19) of the waived positions were approved. The programs represented 19 specialties and 14 states.

During 1979, 34 programs requested a total of 140 waived positions. One hundred and eight (108) were approved. The programs represented twelve specialties and twelve states.

During the first four months of 1980, 35 programs requested a total of 206 waived positions; 137 have been approved. Although the programs represent eleven specialties and twelve states, 168 of the positions were requested by New York hospitals.

Controls

Congress provided that in no case will substantial disruption waivers result in a number to exceed the total number of alien physicians participating in programs of graduate medical education or training in the United States on January 10, 1978.

ECFMG monitors the exchange visitor program via a computerized record system. This system permits verification of program start dates and duration of stay for each exchange visitor being sponsored. The system also provides yearly reports which in addition to providing specific information on exchange visitors also provides total counts.

Despite a substantial increase in waiver requests in 1980, the exchange visitor count is 43% less than the January 10, 1978 index of 3,531.

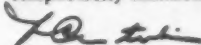
In conclusion, from ECFMG's perspective, extension of the waiver provision through December 1983 would not increase the Exchange Visitor numbers to the point of running contrary to the intent of the law, nor would it result in exceeding the January 10, 1978 "cap" imposed by the Congress. Extending the waiver provision would, however, give areas such as New York a more realistic period of time to develop and carry out plans to phase down reliance on alien physicians. The procedures currently being implemented to carry out the waiver provision permit the appeal board to monitor the requesting institution's respective situation. Programs and institutions currently provide information regarding alternative provider resources, recruitment efforts geared toward the U.S. medical student population and future plans to phase down reliance on alien physicians.

EFFECTIVENESS AND VALUE OF INTERNATIONAL EXCHANGE

As stated earlier, there is increasing concern among foreign nations that graduate medical education in the United States is becoming less accessible, thus forcing these countries to send their medical graduates to countries where graduate medical education is less well-developed. A case in point as relayed to me while in Egypt is the frustration experienced by Egyptian physicians who during the 1960's and early 70's obtained their graduate training in the Soviet Union. It is the knowledge of this experience that has caused Egyptian officials and medical educators to express concern over the United States closing its doors. Officials and leaders in the medical profession from several countries I visited during 1977 and 1978 also expressed the same concern. Consequently, from the ECFMG perspective, foreign countries do rely on the availability of the top quality medical education this country has to offer.

This concludes my prepared statement. I will be pleased to answer questions of the Chairwoman and Members of the Subcommittee.

Respectfully submitted,



Ray L. Casterline, M.D.

SUBSTANTIAL DISRUPTION WAIVERS - 1980

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Illinois	Pediatrics	1 T2 **	0
Kansas	Psychiatry	1 T1 *	1 T1
Maryland	Pathology	1 T1	1 T1
Missouri	Urology	1 T2	0
New Jersey	Pediatrics	2 T1 20 T2	2 T1 20 T2
New York	Anesthesiology	20 T2	20 T2
	Child Psychiatry	3 T2	3 T2
	Family Practice	1 T1	1 T1
	General Surgery	12 T2	12 T2
	Internal Medicine	1 T1 28 T2	1 T1 19 T2
	Pathology	2 T1 3 T2	2 T1 3 T2
	Pediatrics	5 T1 70 T2	5 T1 69 T2
	Physical Medicine	7 T2	7 T2
	Psychiatry	16 T2	13 T2
Ohio	Pathology	1 T2	0
	Pediatrics	2 T2	0
	Therapeutic Radiology	1 T1	1 T1

*T1 = Tier 1

**T2 = Tier 2 Appeal Level

Pennsylvania	Child Psychiatry	1 T1	1 T1
	Pediatrics	1 T2	0
Tennessee	Psychiatry	1 T1	1 T1
Texas	Pediatrics	1 T1	1 T1
	Psychiatry	1 T1	1 T1
Washington, D.C.	Therapeutic Radiology	2 T1	2 T1
Wisconsin	Pathology	1 T1	1 T1
TOTAL		<u>206</u>	<u>187</u>

Revised May 9, 1980

SUBSTANTIAL DISRUPTION WAIVERS - 1979

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Connecticut	Pediatrics	1 T1 *	1 T1
	Psychiatry	1 T1	0
		4 T2 **	4 T2
Georgia	Pathology	1 T1	1 T1
Illinois	Anesthesiology	1 T2	1 T2
	General Practice	1 T1	0
	Psychiatry	1 T1	1 T1
Massachusetts	Anesthesiology	2 T2	0
	General Surgery	1 T1	1 T1
	Neurosurgery	1 T2	1 T2
Michigan	General Practice	1 T1	0
	General Surgery	1 T2	0
	Pediatrics	5 T1	2 T1
New Jersey	Internal Medicine	1 T1	0
		3 T2	0
	Pediatrics	1 T2	0
New York	Anesthesiology	6 T1	6 T1
		8 T2	6 T2
	General Surgery	6 T1	6 T1
	Internal Medicine	9 T1	0
	Neurology	6 T2	6 T2
	Pathology	2 T1	2 T1
		2 T2	2 T2
	Pediatrics	20 T1	20 T1
		30 T2	30 T2
	Psychiatry	2 T1	2 T1
		7 T2	4 T2
	Therapeutic Radiology	1 T2	1 T2

Substantial Disruption Waivers - 1979

Ohio	Anesthesiology	1 T1	1 T1
	Family Practice	1 T1	1 T1
	General Surgery	1 T1	1 T1
	Internal Medicine	3 T1	3 T1
	Neurology	1 T2	1 T2
	Psychiatry	1 T1	1 T1
	Therapeutic Radiology	1 T2	1 T2
Pennsylvania	Ophthalmology	1 T2	1 T2
	Psychiatry	1 T2	0
Tennessee	Internal Medicine	2 T2	0
Texas	Pediatrics	1 T1	0
Washington, D.C.	Pathology	1 T1	1 T1
TOTAL		140	108

* T1 = Tier 1

** T2 = Tier 2 Appeal Level

Rev. March 18, 1980

SUBSTANTIAL DISRUPTION WAIVERS - 1978

STATE	PROGRAM	NUMBER REQUESTED	NUMBER APPROVED
Arizona	General Surgery	2 T1 *	0
Colorado	Pediatrics	2 T1	2 T1
Connecticut	General Surgery	4 T1	0
Illinois	Pediatrics	1 T1	0
Louisiana	Internal Medicine	1 T1	0
Maryland	Pediatrics	1 T1	1 T1
Michigan	Pediatrics	1 T1	0
	Psychiatry	1 T1	1 T1
Missouri	Psychiatry	1 T1	1 T1
New Mexico	Neurology	1 T1	1 T1
New York	General Surgery	3 T1	3 T1
	Pathology	1 T1	1 T1
	Pediatrics	5 T1	1 T1
	Psychiatry	4 T1	4 T1
	Therapeutic Radiology	2 T1	2 T1
North Carolina	General Surgery	1 T1	0
	Neurosurgery	1 T1	0
Ohio	Ob/Gyn	1 T1	1 T1
Pennsylvania	General Surgery	1 T1	1 T1
Puerto Rico	Internal Medicine	1 T1	0
TOTAL		35	19

*T1 = Tier 1

Rev. March 18, 1980

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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February 19, 1980

MEMORANDUM

TO: United States Medical School Deans
Hospital Administrators
Institutional Directors of Medical Education
Graduate Medical Education Training Program Directors
and Training Program Liaison Personnel

FROM: Executive Director, ECFMG

SUBJECT: Background Information and Application Procedures for Substantial Disruption Waivers

Last April, I mailed a memorandum describing amendments to the Immigration and Nationality Act in which the Congress applied stringent requirements for the issuance of J-1 (Exchange Visitor) Visas to alien physicians. Congress then provided for the waiver of certain portions of those requirements, if rigorous implementation of all of the provisions of that section of the law would cause a "substantial disruption in health services."

I am enclosing recently-revised background material, instructions and application forms graduate medical education training programs or institutions may use to apply for substantial disruption waivers. The extensive revisions resulted from the joint efforts of the Educational Commission for Foreign Medical Graduates and officials of the Division of Medicine, Bureau of Health Manpower, Health Resources Administration, Department of Health, Education, and Welfare. We believe that the revisions will enable you to gain a better understanding of the waiver mechanism and application procedures.

If you have questions about any aspect of the substantial disruption waiver process, ECFMG will be pleased to respond to your queries and to provide any assistance you may need.

Ray L. Casterline, M.D.

RLC:reg
Enclosures

SUBSTANTIAL DISRUPTION WAIVER APPLICATION

**Calendar Year 1980
Background Information
and
Application Procedure**

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EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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SUBSTANTIAL DISRUPTION WAIVER APPLICATION

PART I - BACKGROUND

Requirements for Issuance of Exchange Visitor (J-1) Visas

Recent amendments to the Immigration and Nationality Act, contained in Public Laws 94-484 and 95-83, require the application of stringent requirements for issuing Exchange Visitor (J-1) Visas to alien physicians who seek to enter the United States to participate in accredited programs of graduate medical education or training.

In brief, these requirements are

- (A) an accredited school of medicine, or any one or more of its affiliated hospitals, must agree in writing to provide or assume responsibility for the graduate medical education or training;
- (B) the alien physician must pass the Visa Qualifying Examination (VQE), must demonstrate competency in oral and written English, must be able to adapt to the educational and cultural environment in which he will be receiving his training, and must have adequate prior education for successful participation in the program;
- (C) the alien must make a commitment to return to his home country upon completion of training in the United States, and his country must provide written assurance that there is need for the alien's services in his country (Attachment 3); and
- (D) the alien will be allowed to stay in this country no more than 2 years, unless additional time is specifically requested by his country for a maximum of one additional year. The extension is for the purpose of continuing the alien's education or training under the specific program for which he or she came to the United States.

Requirement (B) above does not pertain to a graduate of a school accredited by the Liaison Committee on Medical Education. Hence, alien graduates of accredited U.S. or Canadian medical schools are not affected by this requirement. Moreover, an alien physician who was fully licensed to practice medicine in a State on January 9, 1977, held a valid specialty certificate issued by a component board of the American Board of Medical Specialties, and was actually practicing medicine in a State on that date will be considered to have met the examination requirements in (B) above.

The stated intent of these amendments is to decrease reliance on alien physicians and to assure quality medical care for individuals served by these physicians during their participation in graduate medical education training programs.

Substantial Disruption

Because of the expected severe reduction in the number of alien physicians entering the United States annually as a result of these amendments to the law, the Congress provided for waiver of two of these requirements on a case-by-case basis, if a graduate medical education program can demonstrate that application of these requirements would result in a "substantial disruption" of health services.

Under a substantial disruption waiver, an Exchange Visitor Foreign Medical Graduate (EVFMG) is not required to:

1. have an accredited school of medicine, or any one or more of its affiliated hospitals provide the graduate medical education; and
2. pass the Visa Qualifying Examination.

However, an alien physician entering under a substantial disruption waiver must hold ECFMG certification and meet all of the other requirements for issuance of Form IAP-66 (formerly DSP-66) to qualify for an Exchange Visitor (J-1) Visa.

Congress also provided that in no case will these waivers result in a number to exceed the total number of alien physicians participating in programs of graduate medical education or training in the United States on January 10, 1978.

Substantial Disruption Waiver Mechanism

The substantial disruption waiver was developed to permit programs and institutions traditionally placing significant reliance on alien physicians a transition period during which placement of such physicians may continue, but in decreasing numbers. During this transition period, extending through December 31, 1980, programs and institutions are expected to develop alternative provider resources and attract primarily graduates of American medical schools.

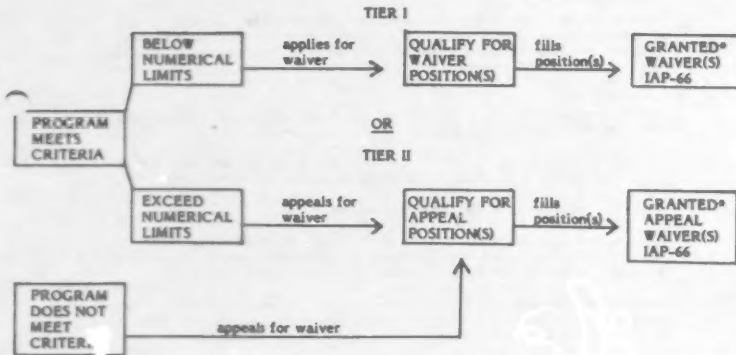
To put the waiver mechanism into effect, the Department of Health, Education, and Welfare (HEW) developed: 1) eligibility criteria to identify programs and institutions affected by these provisions and 2) decreasing numerical limits to permit programs and institutions a gradual rate of phase out for dependency on alien physicians while developing alternative provider resources.

To assist programs or institutions which have a substantial disruption of health services but do not meet the routine specifications developed by HEW, the waiver mechanism provides for an appeal process. A Federal Substantial Disruption Waiver Appeal Board has been established to consider appeals from these programs and institutions.

In essence the waiver mechanism provides for two tiers of waiver application. Tier I is for programs and institutions which meet the eligibility criteria and are requesting waivers within the numerical limitations. Tier II is for programs and institutions which 1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or 2) do not meet the eligibility criteria and can demonstrate a need for waivers based on a substantial disruption of health services.

ECFMG has been designated by federal authorities to process waiver requests and to submit appeal applications to the Federal Board. ECFMG is available for consultation and will provide assistance to programs and institutions at their request.

WAIVER MECHANISM FLOW CHART



Substantial Disruption Waiver Guidelines

When determining eligibility status and the numerical limits, programs must count all alien physicians in the program on January 10, 1978 regardless of visa status, or date of entry into the program.

Programs may submit waiver applications either before or after interviewing alien physicians to fill positions.

Programs may fill waived positions any time during the calendar year, but any unused waived positions may not be carried over into a subsequent calendar year.

Programs or institutions granted* waivers may not subsequently recruit, in excess of the numerical limits, alien physicians who have met the new requirements of the law. However, programs or institutions do have the option to utilize such alien physicians in lieu of using waived positions.

Waivers may be granted for alien physicians entering training programs, so that on December 31 of the respective calendar year, the limits established for that year will not be exceeded.

If no waivers are granted, there is no numerical restriction on the recruiting of alien physicians who have met the new requirements of the law.

Please note: Only those programs utilizing waived positions are restricted by the numerical limits and only for that year in which waiver(s) were first granted.

*Granted - A waiver will be considered to have been granted only upon issuance of a Certificate of Eligibility (Form IAP-66 formerly DSP-66) for the alien physician selected to fill the position.

Length of Validity for Waived J-1 Visa Holders

An individual who obtains a J-1 visa under a waiver may remain in this country without further waiver review for two years, and for one additional year, if the third year is requested by the home country government. However, an individual must apply to ECFMG each year for continuation of Exchange Visitor Sponsorship (IAP-66). Also, waived J-1 visa holders must be counted in determining the program's eligibility for future waivers.

Since waivers are assigned to programs and/or institutions, individual EVFMGs cannot transfer from waived positions to non-waived positions without meeting the new requirements of the law and do so at the risk of loss of their J-1 visa (Exchange Visitor) status.

Criteria for Eligibility and Numerical Limits

The four eligibility categories and their corresponding numerical limits are described below. The rate of phase-out of dependence on alien physicians varies with the category and is consistent with the anticipated impact such phase-out will have on the provision of services as well as the ability of the programs to find alternative resources.

Category AEligibility Criteria

For accredited graduate medical education training programs in anesthesiology, child psychiatry, general practice, nuclear medicine, pathology, pediatrics, physical medicine, psychiatry, or therapeutic radiology, which had more than 25 percent of all their positions occupied by alien physicians on January 10, 1978.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 80 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 70 percent of the number of alien physicians on January 10, 1978.

Category BEligibility Criteria

For accredited graduate medical education training programs in specialties other than those described in Category A above which had more than 25 percent of all their positions occupied by alien physicians on January 10, 1978, AND which provide 50 percent or more of their full time equivalent training in a facility located in a primary medical care manpower shortage area, designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid Patients in calendar year 1977.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 80 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 70 percent of the number of alien physicians on January 10, 1978.

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Category CEligibility Criteria

For accredited graduate medical education training programs which are in specialties or locations other than those described in Categories A or B and had more than 50 percent of all of their positions occupied by alien physicians on January 10, 1978.

Numerical Limits

In 1980, the total number of J-1 visa holders in each program may not exceed 60 percent of the number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in the program may not exceed 40 percent of the number of alien physicians on January 10, 1978.

Special Notes: Training programs under Categories A, B, and C which are conducted in more than one facility as integrated programs and which obtain a waiver for one or more positions must maintain the same percentage of training positions among the participating facilities as was the case on January 10, 1978.

Category DEligibility Criteria

A hospital (a) which had more than 25 percent alien physicians, in total, in its training programs conducted solely within its facilities, on January 10, 1978, AND (b) which is located in a primary medical care manpower shortage area designated under Section 332 of the Public Health Service Act, or had more than 25 percent Medicaid patients in calendar year 1977, may apply for and obtain waivers for those training programs conducted solely within the institution, distributed among such programs at its discretion.

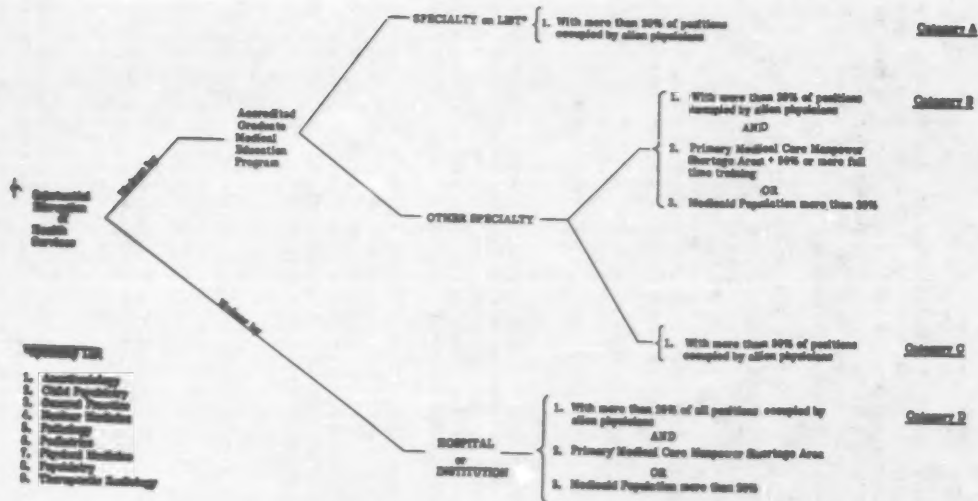
Numerical Limits

In 1980, the total number of J-1 visa holders in such programs may not exceed 80 percent of the total number of J-1 visa holders on January 10, 1978, and the total number of alien physicians in such programs may not exceed 70 percent of the number of alien physicians on January 10, 1978.

A diagram summarizing the eligibility criteria in each category follows.

ELIGIBILITY CRITERIA SUMMARY

Waiver Request For Substantial Disruption of Services



Category 1A

1. Anesthesiology
2. Child Psychiatry
3. General Practice
4. Internal Medicine
5. Pathology
6. Pediatrics
7. Physical Medicine
8. Psychiatry
9. Therapeutic Radiology

Waiver Appeals

Present policy provides for an appeal process for programs or institutions most severely affected by the new requirements for entry of alien physicians as Exchange Visitors. These programs or institutions may have met the eligibility criteria but require waivers in excess of the numerical limits or they may not have met the eligibility criteria and were therefore automatically excluded from obtaining waivers under the Tier I process.

Favorable Action by the Waiver Appeal Board on applications will be based on clear and convincing evidence that, without such waivers, a severe "substantial disruption" of health services would result. These applications must include a full and detailed discussion of the specific problems that programs or institutions anticipate without such waivers, what alternative provider resources and methods have been sought to meet the deficit in health services, and what specific plan will be followed for phasing down, year-by-year, the reliance on alien physicians.

Waiver Application Review Process

There are two tiers of applications and review for waivers:

Tier I - Programs and institutions which meet the eligibility criteria (page 6) and are within the numerical limits may submit applications for waivers such that the number of waivers requested will not result in exceeding the maximum number of alien physicians and J-1 visa holders permissible for that category. ECFMG will be the receipt point for these applications, and will review and process the applications under the numerical limits established for each category.

Tier II - Appeal applications are to be mailed to ECFMG for initial processing. ECFMG will forward appeal applications to the Health Resources Administration of the Department of Health, Education, and Welfare for consideration. A Federal Substantial Disruption Waiver Appeal Board consisting of seven Federal members has been established to review these applications. The appeal board will determine whether programs qualify for additional waivers.

* * * * *

ECFMG will notify programs or institutions when it has been determined that they have qualified for waived positions. A waiver will be considered to have been granted only upon issuance of a Certificate of Eligibility (Form IAP-66) by ECFMG.

ECFMG will issue Certificates of Eligibility only to alien physicians who hold ECFMG Certification and meet other requirements to qualify for Exchange Visitor Visas, including Foreign Government Letters of Assurance of Need (See Attachment 3).

ECFMG will notify the Liaison Committee on Graduate Medical Education (LCGME) of all programs granted waivers. The concern of LCGME and ECFMG is that graduate medical education training programs provide high quality educational programs, which will permit Exchange Visitors to accomplish their training objectives within the limitations of time allowed under the law.

If you have questions or need further clarification, you may contact ECFMG for assistance.

ECFMG
3624 Market Street
Philadelphia, Pa. 19104
Telephone: Area Code 215: 386-5900

PART II - WAIVER APPLICATION PROCEDURE

Applying for a waiver, under any category, will consist of retrieving and compiling information and performing basic percentage calculations. Once you have reviewed all of the information, and are ready to request a waiver, follow these procedures.

Tier I - Waiver Application

1. Select the category (or categories) that best serve your situation based on the diagram summarizing the eligibility criteria (see page 6).
2. Obtain the information that you will need from any one or more of the following sources:

ECFMG	a) number of J-1 visa holders under ECFMG sponsorship in training programs on January 10, 1978
Hospital Administration	a) Medicaid population figures for inpatient admissions for <u>calendar year</u> 1977
	b) total number of inpatient admissions for <u>calendar year</u> 1977
	c) primary medical care manpower shortage area designation information
Health Systems Agency or State Health Planning and Development Agency	a) primary medical care manpower shortage area designation information
Hospital Director of Medical Education or Program Director	a) number of alien physicians in training programs
	b) percentage of training time provided in physician shortage area
3. Select the appropriate Waiver Application(s). For example, if applying for a Waiver under Category B, please use the application labeled Category B. Copies of Waiver Applications are appended.
4. Be sure to complete each of the four sections of the waiver application. An application will not be processed if it is incomplete or filled out incorrectly.
5. When calculating percentages in Section II Determination of Eligibility, a fraction will be considered to have exceeded the previous whole number.

e.g. 25.1% will be considered to be greater than 25%

When calculating numerical limits in Section III Calculation of Numerical Limits, if a fraction occurs, do not raise it to the next highest whole number.

e.g. 50% of 75 = 37.5
37 is the acceptable figure, not 37.5 or 38

6. In all categories, when calculating the number of alien physicians, include all non-United States citizen medical school graduates regardless of visa status (immigrant/non-immigrant) or location of medical school of graduation (includes alien graduates of United States and Canadian medical schools).
7. Forward the completed Waiver Application to ECFMG.

Tier II - Waiver Appeal Applications

- A. For programs or institutions which meet the eligibility criteria described in Categories A, B, C, or D and require waived positions beyond the established numerical limits (see Waiver Application, Section III, line C and D):
 1. Complete a Tier I Waiver Application in accordance with the instructions above.
 2. Complete a Tier II Waiver Appeal Application providing the information requested in detail. Supporting documentation is essential.
 3. Complete the Population and Distribution of Trainees Data Display through calendar year 1981.
 4. Forward the Application(s), the Population and Distribution of Trainees Data Display(s) and the Narrative(s) to ECFMG.
- B. For programs or institutions which are not eligible for Categories A, B, C, or D:
 1. Complete a Category E Waiver Application Form.
 2. Complete a Tier II Waiver Appeal Application providing the information requested in detail. Supporting documentation is essential.
 3. Complete the Population and Distribution of Trainees Data Display through calendar year 1981.
 4. Forward the Application(s), the Population and Distribution of Trainees Data Display(s) and the Narrative(s) to ECFMG.

ECFMG will be responsible for transmitting applications for appeals to the Federal Substantial Disruption Waiver Appeal Board chaired by the Administrator, Health Resources Administration, Department of Health, Education, and Welfare.

Please note, an incomplete appeal application will not be transmitted to the Waiver Appeal Board for consideration.

Part III - Attachments

1. Waiver Applications (Categories A, B, C, D, and E)
2. Waiver Appeal Application and Population and Distribution of Trainees Data Display
3. Foreign Government Letter of Assurance of Need

NOTE: The attached blank application forms are to be used as masters.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY A

Training Programs in Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution: _____ JCAH Number _____

Address: _____

Training Program
Responsible Official: _____ Phone: _____

Program: _____

Is this an integrated program at more than one facility: YES _____ NO _____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 25 percent of the positions in an approved training program in a specialty listed below were occupied by alien physicians* on January 10, 1978, the training program may apply for a Category A waiver for that specialty: Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

A. Total Number of Positions Occupied on January 10, 1978
at all levels of the Training Program (PGY I, II, etc.) _____

B. Total Number of Positions Occupied By Alien Physicians
on January 10, 1978 (This number includes permanent, H
and J-1 visa holders) _____

C. Line B/line A x 100% (must exceed 25%) _____

If you meet the eligibility criteria, proceed to Section III.

*Alien Physicians: All non-United States citizen medical school graduates.

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

- A. Total Number of J-I Visa Holders In This Program on January 10, 1978. _____
- B. Total Number of Alien Physicians In This Program on January 10, 1978. (This number includes permanent, H, and J-I visa holders) _____

Limits for 1980:

- C. J-I Visa Holders Line A x 80% = _____
- D. Alien Physicians Line B x 70% = _____

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

- A. Number of J-I Visa Waivers Requested for 1980 _____
- B. Number of J-I Visa Holders With Waivers From Prior Years Projected on December 31, 1980 _____
- C. Number of J-I Visa Holders Not Holding Waivers Projected On December 31, 1980 _____
- D. Number of other Alien Physicians Not Holding Waivers Projected On December 31, 1980. (This number includes permanent and H visa holders) _____
- E. Line A + Line B + Line C (Cannot exceed Section III, Line C, 1980) _____
- F. Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D, 1980) _____

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-I visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER 1 - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY B

Training Programs Other Than Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution: _____ JCAH Number: _____

Address: _____

Training Program
Responsible Official: _____ Phone: _____

Program: _____

Is this an integrated program at more than one facility: YES _____ NO _____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 25 percent of the positions in an approved training program in a specialty other than those listed in Category A were occupied by alien physicians* on January 10, 1978, AND provide 50 percent or more of their full-time equivalent training in a facility located in a primary medical care manpower shortage area or had more than 25 percent Medicaid patients in calendar year 1977, the training program may apply for a Category B waiver for that specialty.

A program must qualify under (1) AND either (2) or (3).

I. Percent Training Positions.

- A. Total Number of Positions Occupied on January 10, 1978 at all levels of the Training Program _____
- B. Total Number of Positions Occupied By Alien Physicians on January 10, 1978 (This number includes permanent, H and J-1 visa holders) _____
- C. Line B/Line A x 100% (must exceed 25%) _____

*Alien Physicians: All non-United States citizen medical school graduates.

AND

2. Percent time in physician shortage area, as defined by Section 332 of the Public Health Service Act.

- A. Total Number of Weeks in Educational Program _____
- B. Number of Weeks of A in Physician Shortage Area _____
- C. Line B/Line A x 100% (must be 50% or more) _____
- D. Provide a narrative statement of i) educational program; ii) types of training and locations of physician shortage areas in terms of Section 332

OR

3. Percent Medicaid Patients

- A. Total Number of Inpatient admissions* from January 1, 1977 - December 31, 1977 _____
- B. Total Number of Medicaid Inpatient admissions* from January 1, 1977 - December 31, 1977 _____
- C. Line B/Line A x 100% (must exceed 25%) _____

If you meet the eligibility criteria, proceed to Section III

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

- A. Total Number of J-1 Visa Holders in This Program on January 10, 1978 _____
- B. Total Number of Alien Physicians in This Program on January 10, 1978 (This number includes permanent, H, and J-1 visa holders) _____

Limits for 1980

- C. J-1 Visa Holders Line A x 80% = _____
- D. Alien Physicians Line B x 70% = _____

*Inpatient Admissions: Includes each time an individual enters the institution through a routine admission process. Short term holding in the emergency room for observation will not qualify under this definition. Actual admission for diagnostic and/or therapeutic procedures are countable.

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

- A. Number of J-1 Visa Waivers Requested for 1980 _____
- B. Number of J-1 Visa Holders With Waivers From Prior Years projected on December 31, 1980 _____
- C. Number of J-1 Visa Holders Not Holding Waivers projected on December 31, 1980 _____
- D. Number of other Alien Physicians Not Holding Waivers projected on December 31, 1980 (This number includes permanent and H visa holders) _____
- E. Line A + Line B + Line C (Cannot exceed Section III, Line C., 1980) _____
- F. Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D., 1980) _____

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES

TIER I - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY C

Training Programs Other Than Anesthesiology, Child Psychiatry, General Practice, Nuclear Medicine, Pathology, Pediatrics, Physical Medicine, Psychiatry, and Therapeutic Radiology.

Complete one form for each applicable program.

I. Identification

Institution: _____ JCAH Number: _____

Address: _____

Training Program
Responsible Official: _____ Phone: _____

Program: _____

Is this an integrated program at more than one facility: YES _____ NO _____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

II. Determination of Eligibility

If more than 50 percent of the positions in an approved training program in any specialty other than on the list were occupied by alien physicians* on January 10, 1978, the training program may apply for a Category C waiver.

A. Total Number of Positions Occupied On January 10, 1978
at all levels of the training program _____

B. Total Number of Positions Occupied By Alien Physicians on
January 10, 1978 (This number includes permanent, H and J-1
visa holders) _____

C. Line B/Line A x 100% (must exceed 50%) _____

If you meet the eligibility criteria, proceed to Section III.

III. Calculation of Numerical Limits

For each training program meeting eligibility criteria to apply for a waiver under Section II above:

A. Total Number of J-1 Visa Holders in This Program on January 10,
1978 _____

B. Total Number of Alien Physicians in This Program on January 10,
1978 (This number includes permanent, H, and J-1 visa holders) _____

*Alien Physicians: All non-United States citizen medical school graduates.

Limits for 1980:

- C. J-1 Visa Holders Line A x 60% = _____
- D. Alien Physicians Line B x 40% = _____

IV. Waiver Request

Waivers are requested for this program in the following numbers for 1980. These must be within the limits determined under Section III above.

- A. Number of J-1 Visa Waivers Requested for 1980 _____
- B. Number of J-1 Visa Holders With Waivers from
Prior Years Projected On December 31, 1980 _____
- C. Number of J-1 Visa Holders Not Holding Waivers
Projected On December 31, 1980 _____
- D. Number of Other Alien Physicians Not Holding Waivers
Projected On December 31, 1980 (This number includes
permanent and H visa holders) _____
- E. Line A + Line B + Line C (Cannot exceed Section III,
Line C, 1980) _____
- F. Line A + Line B + Line C + Line D (Cannot exceed
Section III, Line D, 1980) _____

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES
TIER 1 - WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY D

Hospital Request for Programs Conducted Solely Within Its Facilities.

I. Identification

Hospital: _____ JCAH Number _____

Address: _____

Training Program
Responsible Official: _____ Phone: _____

Programs: (list all programs conducted solely within a hospital's facilities which are to be included in waiver request.)

(Use continuation sheets, if necessary.)

II. Determination of Eligibility

If a hospital had more than 25 percent alien physicians* in total, in its training programs conducted solely within its facilities, on January 10, 1978, AND is located in a primary medical care manpower shortage area or had more than 25 percent Medicaid patients in calendar year 1977, the hospital may apply for a Category D Waiver.

A program must qualify under I AND either 2 or 3

I. Percent Training Positions

- A. Total Number of Training Positions Occupied at all Levels in Programs Conducted Solely Within the Facilities on January 10, 1978 _____
- B. Total Number of Positions Occupied by Alien Physicians in these Programs on January 10, 1978 (This number includes permanent, H and J-1 visa holders) _____
- C. Line B/Line A x 100% (must exceed 25%) _____

*Alien Physicians: All non-United States citizen medical school graduates.

AND

2. Check if hospital is located in a physician shortage area as defined by Section 332 of the Public Health Service Act _____

Provide location description in terms of Section 332 _____

OR

3. Percent Medicaid Patients

- A. Total Number of Inpatient Admissions* from January 1, 1977 - December 31, 1977 _____
- B. Total Number of Medicaid Inpatient Admissions* from January 1, 1977 - December 31, 1977 _____
- C. Line B/Line A x 100% (must exceed 25%) _____

If you meet the eligibility criteria, proceed to Section III.

III. Calculation of Numerical Limits

For hospitals or institutions meeting eligibility criteria to apply for a waiver under Section II above:

- A. Total Number of J-1 Visa Holders in These Programs on January 10, 1978 _____
- B. Total Number Alien Physicians in These Programs on January 10, 1978 (This number includes permanent, H, J-1 visa holders) _____

Limits for 1980

- C. J-1 Visa Holders Line A x 80% = _____
- D. Alien Physicians Line B x 70% = _____

IV. Waiver Request

Waivers are requested for these programs at this hospital in the following numbers for 1980. These must be within the limits determined under Section III above.

*Inpatient Admissions: Includes each time an individual enters the institution through a routine admission process. Short term holding in the emergency room for observation will not qualify under this definition. Actual admission for diagnostic and/or therapeutic procedures are countable.

	Identify:	Residency Code Number	Total
A.	Number of J-1 Visa Waivers Requested for 1980	____ + ____ + ____ + ____ + ____	_____
B.	Number of J-1 Visa Holders With Waivers From Prior Years Projected on December 31, 1980	____ + ____ + ____ + ____ + ____	= _____
C.	Number of J-1 Visa Holders Projected On December 31, 1980 <u>Not Holding Waivers</u>	____ + ____ + ____ + ____ + ____	= _____
D.	Number of Other Alien Physicians Projected on December 31, 1980, Not Holding Waivers (This number includes permanent and H visa holders)	____ + ____ + ____ + ____ + ____	= _____
E.	Line A + Line B + Line C (Cannot exceed Section III, Line C, 1980)	____ + ____ + ____ + ____ + ____	= _____
F.	Line A + Line B + Line C + Line D (Cannot exceed Section III, Line D, 1980)	____ + ____ + ____ + ____ + ____	= _____

Note: In Section IV, if identifying more than 4 programs, make additional lines or use a continuation sheet.

If the figures in lines E or F exceed the numerical limits established in Section III, lines C or D, submit an appeal application with this form for the number of J-1 visa positions desired in excess of the established limits.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES
WAIVER APPLICATION FOR CALENDAR YEAR 1980

CATEGORY E

Training Programs which are not eligible for Categories A, B, C, or D.

Complete one form for each applicable program.

I. Identification

Institution: _____ JCAH Number: _____

Address: _____

Training Program
Responsible Official: _____ Phone: _____

Program: _____

Is this an integrated program at more than one facility: YES _____ NO _____

If Yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents.

II. Background

1. Percent Training Positions

A. Total Number of Positions Occupied on January 10, 1978
at all levels of the Training Program _____

B. Total Number of Positions Occupied By Alien Physicians*
on January 10, 1978. (This number includes permanent,
H and J-1 visa holders) _____

C. Line B/Line A x 100% _____

2. Percentage of full-time equivalent training in a facility located in a primary medical care manpower shortage area, as defined by Section 332 of the Public Health Service Act.

A. Total Number of Weeks in Educational Program _____

B. Number of Weeks of A in Physician Shortage Area _____

C. Line B/Line A x 100% _____

*Alien Physicians: All non-United States citizen medical school graduates.

3. Number of Medicaid patients in calendar year 1977

A. Total Number of Inpatient admissions* from
January 1, 1977 - December 31, 1977

B. Total Number of Medicaid Inpatient admissions*
from January 1, 1977 - December 31, 1977

C. Line B/line A x 100%

* Inpatient Admissions: Includes each time an individual enters the institution through a routine admission process. Short term holding in the emergency room for observation will not qualify under this definition. Actual admission for diagnostic and/or therapeutic procedures are countable.

SUBSTANTIAL DISRUPTION OF HEALTH SERVICES
 WAIVER APPEAL APPLICATION FOR CALENDAR YEAR 1980

I. Identification

Institutions: _____ JCAH Number: _____

Address: _____

Training Program

Responsible Official: _____ Phone: _____

Programs: _____

Is this an integrated program at more than one facility: YES ___ NO ___

If yes, list all facilities utilized on a continuation sheet and describe the program in terms of number of residents and time spent at each site.

Indicate the number of waived positions that will be necessary to meet the 1980 program requirements.

II. Narrative Justification

To judge the needs of programs and institutions for substantial disruption waivers, the following issues and questions must be addressed in the narrative as they relate to the utilization of resident manpower.

1. Patient case load and service patterns utilized by the hospital.
 - A. What was the patient case load in the base calendar year 1977 and in calendar year 1979: inpatient and outpatient?
 - B. What is the projected patient case load for 1980: inpatient and outpatient?
 - C. What are the treatment responsibilities of professional staff, particularly the residents, with respect to the identified patient case load?
2. Health service needs met by the program.
 - A. What health service needs of the community are currently met by the program?
 - B. If waivers were not granted how would this affect the patients served by the program and the level of services provided to them.
3. Alternatives and plans to phase down reliance on alien physicians.
 - A. What efforts are being made to recruit U.S. medical school graduates and U.S. citizen foreign medical school graduates?
 - B. What methods will be used to attract graduates of American medical schools in the future?

- C. What non-physician manpower alternatives to alien physicians are being utilized?
 - D. If non-physician manpower alternatives are not being utilized but are planned, specify 1) implementation schedule, and 2) anticipated constraints/problems and plans for resolution.
 - E. What other alternatives are being considered such as, but not limited to, restructuring or integrating residency programs?
4. Indicate whether you qualified, in 1980, for waived positions to reach the numerical limits. If yes, indicate whether the 1980 waived positions under the pre-established limit have been filled.

III. Complete the attached data display.

POPULATION AND DISTRIBUTION OF TRAINEES DATA DISPLAY*

Directions

- Complete the data display for each accredited training program or institution filling an appeal application.
- In display I, indicate the number and distribution of trainees who were present on the Base Date, January 10, 1978 as categorized PG I, PG II, etc.
- In display II, indicate the number and distribution of trainees who would be present on December 31, 1980. Indicate above the slash mark (/) the number in each category if no appeal waivers are qualified for in 1980. This figure should include all waived positions granted prior to 1980 and all Tier I waived positions qualified for in 1980. Indicate below the slash mark (/) the number anticipated in each category if the program should qualify for these 1980 appeal waivers.
- In display III, indicate the number and distribution of trainees who would be present on December 31, 1981.

I. BASE: January 10, 1978

	Total Prog	US Citizen NO	Foreign FMS	Alien Physicians Total	P	H	J
PG I							
PG II							
PG III							
PG IV							
PG V							
PG VI							
PG VII							
Total							

II. December 31, 1980 without/with waivers

	Total Prog	US Citizen NO	Foreign FMS	Alien Physicians Total	P	H	J
PG I							
PG II							
PG III							
PG IV							
PG V							
PG VI							
PG VII							
Total							

III. December 31, 1981

	Total Prog	US Citizen NO	Foreign FMS	Alien Physicians Total	P	H	J
PG I							
PG II							
PG III							
PG IV							
PG V							
PG VI							
PG VII							
Total							

103

* The data display is to be filled out when making application for waiver appeals only.

Name of Applicant for Visa: _____

There currently exists in (country) a need for qualified
 medical practitioners in the specialty of _____

(Name of applicant for Visa) has _____ and a written assurance
 with the government of this country _____ he/she will return
 to this country upon completion of training in the United
 States and intends _____ the practice of medicine in
 the specialty for which training is being sought.

Stamp (official and signature)

of issuing official of named
 country.

Dated:

 Official of named Country

Attachment 3

Ms. HOLTZMAN. Our final witness will be Mr. Leonard Fenninger of the American Medical Association.

Dr. FENNINGER. I have with me Mr. Ross Rubin, the director of the Department of Federal Legislation in the American Medical Association. We are pleased to be here to speak to H.R. 7118, because it deals with two fundamental matters that long have been of interest, long recognized by the American Medical Association; namely, foreign medical graduates have for decades contributed and continue to contribute substantially, to the development of new medical knowledge and technology in the United States, medical education and the medical care of residents within this country.

They have, especially since World War II, made major contributions to biomedical science, medical education, and medical services throughout the world.

H.R. 7118 clearly recognizes these two important principles. We are in strong support of the provision which would remove the requirement for board certification, certification by a recognized American specialty board for those alien foreign medical graduates who are here on exchange visitors visas and who are duly licensed and practicing in the United States before January 9, 1977.

We would strongly support the provision which is included in this bill and their exemption from requirements for the VQE as a means of continuing to hold their visas.

We also strongly endorse the revision of the current limitation of 2 years of the training period and the clear indication that those people from other nations, foreign medical graduates from other nations, coming to the United States to an accredited residency program, would be able to stay according to a prior plan agreed to by the institution and the United States, the nation or origin, and the candidate himself. He would be able to stay not only for the full duration of the educational program in the specialty and subspecialty in an accredited institution, but also would be given a year's leeway in which to develop some degree of acculturation to the United States, ease with language, and might discover during that course of the year that another field was more suited both to the needs of the country from which he comes and to his own tastes.

So we would commend this bill in those two respects.

While we are acutely aware and greatly concerned about the fact that persons needing medical care in the United States do not have access to it, particularly in large cities and some rural areas, particularly in the industrial Northeast—this has already been pointed out.

At the time the waiver provision was first introduced, we supported that as a temporary measure for the culmination necessary in these kinds of institutions for the service of people who needed medical care.

Nevertheless, we believe the provisions in H.R. 7118 which essentially equate unfilled residency positions with shortage of medical services and would allow National Health Service Corps members to fill these vacancies and undertake their residencies while fulfilling their National Health Service Corps obligations should not be enacted. Institutions with these vacancies would probably qualify under the existing law, and the additional legislation is not needed.

We do not believe the absence of a vacancy in a residency position should be equated with insufficient medical services provided by physicians.

The provision does not recognize that graduate medical education or residency has as their purpose education through service. Although a resident does provide important and valuable service to patients under the supervision of experienced clinical teachers, the residency program must have a strong educational base. That's its very foundation.

The primary purpose of a residency is not to provide medical services. Therefore, we believe the provisions as they are now written are not suitable for the purposes of alleviating shortages of medical services and equating that relief with residency education.

Incidentally, the Health Service Corps was not intended to fill residency positions. It was intended to have services available from fully qualified, fully trained physicians.

We commend the requirements in the bill for a much closer monitoring, much more thoughtful and careful planning, and indication of solutions to the service problems separate from the question of the quality of residency education; and we comment your recognition that this is a temporary expedient and not a long-term solution.

I am sure you are aware that the increase in the number of graduates from U.S. medical schools has been very rapid in recent years, and there has not been a comparable increase in the number of residency positions; and I think we can look forward to a redistribution of U.S. medical graduates in residencies, many of which are currently of varying quality, but are not filled for reasons some of which were mentioned by the group from New York, which I thought presented very clearly and well their views; but many of them are not filled because of quality of education, which is often of excellent quality but, because there are other places of similar quality in much more desirable circumstances for alerting and for taking care of patients.

We'd be glad to answer your questions.

[The complete statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, PRESENTED BY
LEONARD D. FENNINGER, M.D.

Madame Chairwoman and members of the committee: My name is Leonard D. Fenninger, M.D. I am Group Vice-President for Medical Education of the American Medical Association. With me today is Ross Rubin, Director of AMA's Department of Federal Legislation.

The American Medical Association is pleased to have this opportunity to comment on H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the immigration and entry status of certain foreign medical graduates (FMGs). The bill is designed to address problems caused by amendments to the Act made by the Health Professions Education Assistance Act (Public Law 94-484) and the Public Health Service Act Amendments of 1977 (Public Law 95-83).

These amendments altered the immigration status of foreign medical graduates under law by significantly modifying requirements for both immigrant and non-immigrant foreign born and trained physicians. In effect, these changes in the law severely limited the preferences available to FMGs under then existing immigration law. These changes were in response to problems perceived by the Congress concerning the continued numerical growth of foreign born and trained physicians in the United States. First, there was a significant concern that our immigration policies were encouraging capable practitioners to leave their own countries, causing a shortage of physicians—the so-called "brain drain" from

emerging nations. A second concern expressed by some critics at the time of the amendments was that some FMGs had not received *medical training that was comparable to that provided in this country*. The 1976 and 1977 amendments were designed to curb the entry of foreign born physicians into the United States.

Before addressing the specific problems raised by these amendments, I would like to point out that well-trained physicians can and do deliver high quality medical care in this country, regardless of their native country. FMGs in this country have, for decades, provided valuable services to the patients of this nation and have improved the quality of care in many areas.

Public Law 94-484 made the following changes in existing immigration law relating to FMGs:

Eliminated the immigration preference for alien physicians, unless the physician had passed Parts I and II of the National Board of Medical Examiners Examination (National Boards) or an equivalent exam, and had demonstrated competency in the English language; and

Added new provisions concerning non-immigrant FMGs whereby assurance of an exchange-visitor visa (J-visa) is conditioned upon the physician's participation in a program sponsored by a U.S. medical school or other recognized medical institution, passage of Part I and Part II of the National Boards (or an equivalent exam), and commitment to return to his or her country of origin upon the completion of training. Also, the J-visa would be limited so that a physician could remain in the country for only two years (with provision for a one-year extension).

The J-visa requirements were postponed until December 30, 1980, for FMGs participating in accredited programs in a medical facility where such program would be substantially disrupted if the provision was implemented.

After enactment of these changes, significant and unanticipated problems developed that needed addressing with subsequent legislation. First, since an equivalent to Parts I and II of the National Boards (offered only in the United States) was not available, an extension of one year was provided by Public Law 95-83 for the testing requirement for J-visa applicants. Public Law 95-83 also modified the requirement for passage of Parts I and II of the National Boards for those immigrant alien physicians who, on January 9, 1977, were fully and permanently licensed in a state to practice medicine, were in active practice in that state and held a valid specialty certificate issued by a constituent board of the American Board of Medical Specialties.

While designed specifically to reduce the number of FMGs immigrating permanently to the United States, the changes made by both Public Law 94-484 and Public Law 95-83 had the impact of jeopardizing the status of many licensed FMGs already practicing in the United States when the amendments went into effect and caused a significant problem for exchange-visitor visa holders to complete an accredited medical residency program in the United States.

H.R. 7118 is designed to alleviate these problems by eliminating the board certification required for FMGs licensed to practice medicine on January 9, 1977; lengthening the time limit for exchange-visitor visas, to allow an alien to remain (on the basis of prior agreement) for the time typically required to complete the resident's program (as determined by the Director of the International Communications Agency with consultation with the Secretary of HHS); providing that the student could change programs once within the student's first two years in the U.S.; and with respect to the waiver of full J-visa requirements for programs that would be substantially disrupted extending the waiver provision for an additional two years (or three years for those programs that have substantially reduced their reliance on FMGs during the the first two-year waiver).

The Secretary of HHS and the Attorney General would be required to report to Congress on the distribution of FMGs in the U.S., including an analysis of the dependence of various communities on FMGs in training programs. A study would also be conducted to evaluate the value to foreign nations and the U.S. derived from exchange visitor programs in graduate medical training. Finally, the bill would provide that any hospital that is granted a severe discretion waiver will be deemed a health manpower shortage area eligible for assignment of National Health Service Corps members, with participation in such a residency program by Corps members counted toward satisfying the individual's service obligation.

THE BOARD-CERTIFICATION REQUIREMENTS

For FMGs to remain in this country after the amendments went into effect (January 9, 1977), the law requires the physician to pass Parts I and II of the National Boards and meet the English language competency requirement, or in the alternative be permanently licensed to practice medicine in a state, be actively practicing medicine in that state, and be board-certified in a medical specialty on the effective date of the Act.

This provision raises two problems for some alien physicians who were in the country in January 1977. First, the law fails to make provision for physicians who had taken the FLEX exam for medical licensure in December 1976, but who had not received the results of that examination prior to the law's effective date. While not being fully licensed, physicians who passed the exam would have been eligible for licensure had the FLEX exam been graded earlier.

We are also concerned with the provisions that require, along with state licensure, an FMG to hold medical specialty certification in order to maintain his or her status without further examination. We object specifically to this provision because it fails to recognize the role of board-certification in the United States. Board-certification is not meant to, nor does it, affect the legal status or a physician's right to practice medicine. Board-certification is a voluntary act by a physician. The certifying boards are not the instrumentality of any government agency. Board-certification does not necessarily mean that a physician will provide superior care, nor does lack of board-certification lead to the conclusion that a physician will provide inferior care.

It is because of these facts about board-certification that we support the provision in H.R. 7118 to delete the board-certification requirement. Full licensure by a state should be retained as the only requirement for maintaining immigration status for an FMG practicing medicine in the U.S. when the Act became effective. We recommend H.R. 7118 be modified so that physicians who took and passed the December 1976 FLEX exam and were therefore eligible for licensure on the law's effective date would be considered licensed on the law's effective date for the purposes of the January 9, 1977, license requirement.

J-VISITOR VISA PROVISIONS

We are also concerned with and recommend modifications to the length-of-stay requirements found in the exchange-visitor visa provisions. Currently, the law limits the length of stay in the United States under such a visa for two years (with an extension of one year available). This limitation does not take into account the nature of existing programs for graduate medical education in the United States. Most residency programs now last a minimum of three years and in many cases are even longer. Most J-visa holders enter into regular residency programs and expect to complete the entire training program. Completion of full programs are of benefit to both the physicians and to their nations of origin. However, the existing limitation often prevents the physician from receiving the benefit of a full training program. While the U.S. is the leading center of medical education worldwide, some physicians, principally from emerging nations, are choosing to enter residencies in other countries due to their inability to complete full programs in the United States.

The American Medical Association has developed draft legislation designed to remedy this situation and allow FMGs to avail themselves of full residency training programs. The draft bill (attached) would amend the immigration law to let FMGs on exchange-visitor visas remain in the U.S. for the duration of an approved residency program in which they are participating. Such FMGs would be permitted to change programs once during their stay if the changes were made within two years of entry into the U.S. The draft bill changes only the duration of stay and does not affect any other requirements for obtaining a visa. FMGs would be able to complete a residency, but would be bound by all other requirements, such as the requirement that they return home at the completion of their training.

We are pleased to note that this draft bill has substantially been incorporated in H.R. 7118. We believe that this proposed change in the immigration law properly recognizes the availability and kinds of graduate medical education programs now offered in the U.S. It would also enable those nations that wish to send their physicians to this country for advanced training to do so. We believe that the

medical care and educational system in this country is unequalled and that it is in the best interest of this country and other nations, especially emerging nations, that we share our expertise with them.

SUBSTANTIAL DISRUPTION WAIVER

H.R. 7118 would extend for two years (and possibly three years) the provision found in existing law that allows FMGs to enter into graduate training programs without having met the full J-visa requirements upon a finding by the Secretary of HHS (on a case-by-case basis) that there would be a substantial disruption in the health services provided by such program. In order to receive a waiver, the sponsors of the residency program would be required to provide the Secretary a comprehensive plan to reduce its reliance on FMGs. The plan would have to discuss the problems that would be caused if no waiver were granted, alternate resources available to deal with the problem, a description of changes in the program that would be made to make the program more attractive to American graduates and recruitment efforts in this regard, and a detailed description on how the program will meet the needs by the end of the waiver period.

The AMA supports the provision in the bill that would substantially reduce the adverse impact that full implementation of the J-visa requirements would have on the delivery of medical services for certain hospitals that have relied heavily on FMGs to participate in their residency programs. The provision to extend the substantial disruption waiver authority properly focuses on the short-term nature of the problem by limiting such waiver to no more than three years. The requirement for the Secretary to mandate a plan indicating how the hospital is attempting to eliminate its dependence on foreign-trained residents should be strictly enforced so that these programs take all necessary actions to attract non-alien participants. With the increased number of students graduating from American medical schools, it is our view that the problem of filling residency positions will not be long-term for programs providing quality training and that the Secretary, in granting continuing waivers, should assure that all reasonable efforts are made in this regard.

HEALTH MANPOWER SHORTAGE AREA

The bill also provides that any hospital that has a residency program for which a substantial disruption waiver has been granted shall be deemed a health manpower shortage area "with the greatest health manpower shortage." National Health Service Corps members could then be assigned to the hospital to replace FMGs. A Corps member may choose to serve his or her residency in such a program, with such service counted toward meeting the individual's service obligation.

In our view, this provision is not necessary and should not be adopted. First, failure to fill residency positions cannot be equated with manpower shortage areas. Secondly, if a hospital is having severe problems providing necessary services to an underserved population and demonstrates its need, the hospital can seek qualification as a shortage area pursuant to Section 332 of the Public Health Service Act. The provision to extend the waiver addresses a limited and short-term problem. Therefore, a special provision on area designation appears unnecessary in our view of the law. Use of Corps personnel to meet short-falls should be considered only as a last resort to provide necessary services to an underserved population and should not be looked upon as a primary means of staffing inner-city hospitals.

Use of Corps personnel should be limited and provision made to assure that the facility is not allowed to become dependent on Corps personnel in the same fashion that it became dependent on FMGs. Such a provision would just substitute one problem for another.

We are also concerned with the portion of the bill that would allow Corps personnel to meet their service obligation through residency programs in these facilities. The intent and purpose of the National Health Service Corps is to provide quality medical care to underserved populations by physicians who have completed their training, not to provide graduate medical training to its members or to fill empty residency positions. We believe that in a shortage area, physician services under the NHSC should be provided by a fully trained physician.

CONCLUSION

We believe that this Subcommittee has an excellent opportunity to correct some inequities and problems created when Public Law 94-484 amended the Immigration and Nationality Act. We are gratified that this Subcommittee has chosen to address these important issues. America has always opened its doors to foreign nations for many worthwhile purposes and has especially offered the benefits of its medical skills and training to countries whose need is great. The American Medical Association believes that this tradition should be continued.

[—, 96th Congress, 2d session]

A BILL To amend the Immigration and Nationality Act relating to foreign medical graduates

Be it enacted by the Senate and the House of Representatives of the United States of America in Congress assembled,

SECTION 1. Section 212(j) (1) (D) of the Immigration and Nationality Act (8 U.S.C. 1182 (j) (1) (D)) is amended to read as follows:

"(D) The duration of the alien's participation in the program for which he or she is coming to the United States is limited to the time necessary to permit such alien to complete the graduate medical training program designated by such alien; *Provided*, That the time deemed necessary for completion of a graduate medical training program shall be determined by the Director, International Communication Agency, or his delegate, on the basis of the published requirements of the accredited program of graduate medical education in a recognized medical specialty in which the alien seeks specialized education and training; *And provided further*, That, with the approval of the Director, International Communication Agency, or his delegate, such alien may change his or her designation of program no more than once subsequent to his or her admission to the United States and no later than two years after such admission, if, but only if, the government of the country of the alien's nationality or last residence has provided the certification required by subparagraph (C) of this subsection such a graduate medical training program in the United States on the effective date of this Act shall be deemed for purposes of this subparagraph to have been admitted to the United States on that date."

Ms. HOLTZMAN. Thank you very much.

I want to sincerely apologize again for the shortage of time. I want to thank each and every one of you for taking the trouble to come to Washington to testify. I would like to ask if you would have any objection to answering questions submitted in writing to you by members of the subcommittee?

Dr. CASTERLINE. I would be pleased to do so.

Dr. FENNINGER. No objection.

Dr. MYERS. I would be happy to.

Ms. HOLTZMAN. I have a number of questions and will submit them to you.

I will ask other members of the subcommittee if they have questions about your testimony. Again I do want to express my deepest appreciation for you coming here.

The hearing is concluded.

[Whereupon, at 3:45 p.m., the hearing was adjourned.]

APPENDIX

Letter from Honorable Melvin H. Evans, M.C. regarding Foreign medical graduates in the U.S. Virgin Islands

Responses to Questions submitted for the hearing record May 14, 1980

Statements submitted for the hearing record

AHA

Madarang

Article from American College of Surgeons

Report of Office of the City Council President, "Is There a Doctor in the House"

Letter from Dr. Franklin C. Behrle

Proposal submitted by HHC for "Reducing Reliance on Foreign Medical Students"

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C. May 2, 1980.

HON. ELIZABETH HOLTEMAN,

*Chairwoman, Subcommittee on Immigration, Refugees and International Law,
House Committee on the Judiciary, Rayburn House Office Building, Wash-
ington, D.C.*

DEAR CHAIRWOMAN HOLTEMAN: I have recently been advised that you have scheduled hearings in the near future on the subject of foreign medical graduates entering the United States.

This is a matter of tremendous and serious concern to my district, the United States Virgin Islands, which have suffered enormously from an acute shortage of physicians to meet the medical needs in our local public hospitals.

I would very much appreciate the opportunity to testify before your distinguished Subcommittee on this crucial subject.

Thank you for your immediate consideration to my request.

Please accept my best wishes.

Sincerely,

MELVIN H. EVANS,
Member of Congress.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., June 5, 1979.

DEAR COLLEAGUE: We, in the United States Virgin Islands, are presently faced with a critical shortage of physicians in our hospitals and health facilities. This alarming situation has been precipitated primarily by the inability of the Virgin Islands Government to provide competitive salaries to lure qualified physicians from the United States Mainland, and in part to the geographical isolation of the Virgin Islands.

In fact, this physician shortage was a significant factor in the April 1979 loss of accreditation to both Virgin Islands hospitals.

Section 101(a)(15)(H) of the Immigration and Nationality Act (8 U.S.C. 1101 et seq.) has effectively prevented the Virgin Islands Government from attracting qualified physicians from foreign countries to perform essential medical services in local hospital facilities, where there exists a dire need for additional physicians.

To offset the disastrous effect of of this particular provision upon the United States Virgin Islands, I am introducing legislation to exempt the United States Virgin Islands from the limitation of Section 101(a)(15)(H) of the Immigration and Nationality Act.

I hope you will join me in sponsoring this measure. If you would like to co-sponsor, or if you have any questions, please contact either Doug Capdeville or Greg Wims at X51790.

Cordially,

MELVIN H. EVANS,
Member of Congress.

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES,
DEPARTMENT OF HEALTH,
January 11, 1978.

Mr. DANTE ROSSI,
Officer-in-Charge,
Immigration and Naturalization Services,
St. Thomas, Virgin Islands.

DEAR MR. ROSSI: There are eight physicians bonded by the Government of the Virgin Islands. They render indispensable service and contribute immeasurably to the professional complement of the hospitals, the Health Department, Public Health and Maternal and Child Health Programs. If their activities were curtailed, considerable hardship would occur to patients and residents of the Virgin Islands.

These physicians have been secured because it has proven virtually impossible to obtain similarly trained professionals from the United States for the salaries which the Government Budget of the Virgin Islands permits.

With a choice between foreign professionals and unavailable U.S. doctors because of salary restrictions, we are forced to the continued use of trained foreign physicians.

Reduction within the Health Department resulting from the termination and prohibition of hiring foreign physicians will create an unacceptable crisis in the Health programs of the Virgin Islands.

Sincerely,

ROY L. SCHNEIDER, M.D.,
Commissioner of Health.

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES,
DEPARTMENT OF HEALTH,
April 6, 1978.

Hon. IVE A. SWAN,
Attorney General,
Department of Law,
St. Thomas, Virgin Islands.

DEAR ATTORNEY SWAN: Several months ago, your predecessor and I discussed the problem of the Department of Health in obtaining Immigration clearance via a waiver of the new Immigration Act on employment in the Virgin Islands.

We had been advised by the late Governor to pursue obtaining a waiver by communicating with Mr. Dante Rossi of the Immigration and Naturalization Service and, if necessary, the U.S. Justice Department.

Following our discussions, my office transmitted a letter to Mr. Rossi on January 11th stating the problems that we have with the new Immigration Act. We mentioned that at present we have approximately eight physicians bonded by the Government of the Virgin Islands. Their services are indispensable due to the fact that because of our geographic separation and our precarious financial status we cannot attract physicians as easily as mainland facilities. Even with their services we still have a dire need for more physicians not only in our hospital facilities, but in all divisions of the Department of Health.

If the activities of the present bonded physicians were curtailed, and if we would not be able to attract other foreign physicians, we are certain there would be hardships in providing even minimal service to the patients and residents of the Virgin Islands. We feel that this situation would create a crisis that would be severely felt throughout the community.

We are therefore requesting that you do whatever is necessary in order to secure for us clearance by the Immigration and Naturalization Service to hire much needed professional personnel. My office would be very happy to furnish you with any further information you may deem necessary.

Because of the high turnover that we experience in the last quarter of each fiscal year, we are requesting that you make all effort to expedite this matter. Your usual cooperation will be greatly appreciated.

Sincerely,

ROY L. SCHNEIDER,
Commissioner of Health.

Enclosure.

OFFICE OF THE ATTORNEY GENERAL,
U.S. Virgin Islands, April 17, 1978.

Re H-1 Physicians.

Mr. DANTE ROSSI,
Officer-in-Charge,
Immigration and Naturalization Services,
St. Thomas, Virgin Islands.

DEAR MR. ROSSI: As you are well aware, by Section C of the Health Professions Educational Assistance Act of 1976, Public Law No. 94-484 (October 12, 1976) Congress made the express finding and declaration of policy that: "There is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording a preference to alien physicians and surgeons in admission to the United States under the Immigration and Naturalization Act."

The effect of this declaration of policy and the amendments to 8 U.S.C. § 1182 (14) and (32) which now makes doctors ineligible to receive visas and requires exclusion of them from the United States, was to destroy the status of nonimmigrant as it formally applied to physicians. These former H-1 physicians are, as of the effective date of this chapter, illegally in this Country and are subject to deportation under 8 U.S.C. § 1258. Further, these alien physicians are excluded from the practice of medicine other than in research and technical capacities by 8 U.S.C. § 1101(a) (15) (H).

It is the understanding of this Office, from letters written by Dr. Roy L. Schneider, Commissioner of Health, that the application of the new Immigration Act on employment of alien physicians would result in an undue and severe hardship upon the available medical services to the residents of the Virgin Islands. Moreover, alien doctors make up a large segment of the Department's medical staff and also provide indispensable and immeasurable professional services to the hospitals, the Department of Public Health and the citizenry of the Virgin Islands.

Additionally, the geographical separation of the Virgin Islands from the Mainland United States, together with our precarious fiscal posture and low pay offered to physicians, makes it exceedingly difficult for the Virgin Islands to attract physicians from the Mainland to our facilities. Consequently, there is currently a dire and urgent need for more physicians in the Virgin Islands. Furthermore, with the application of the new Immigration Act to H-1 physicians presently practicing in the Virgin Islands, this situation becomes critical. Even more distressing is that the inability of the Virgin Islands Government to attract more physicians from the United States to replace the existing compliment of H-1 physicians and its inability to supplement the present number of physicians would prevent the medical facilities in the Virgin Islands from providing even a minimally acceptable service to Virgin Islanders. It is with this acute social problem and the accompanying ramifications of it that this formal waiver request is made.

I have also enclosed for your perusal our entire file on alien physicians along with formal requests for waivers. Accordingly, on behalf of myself, the Government of the Virgin Islands and the people of the Virgin Islands I thank you for your kind and gracious assistance and cooperation in your securing a waiver of the Immigration Naturalization Act to allow our present compliment of H-1 physicians to remain in the Virgin Islands.

I hasten to add, however, that should you need additional information on this matter, my staff and I stand ready to offer our assistance in furnishing it to you.

Sincerely,

IVE ARLINGTON SWAN,
Attorney General.

Enclosures.

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES,
VIRGIN ISLANDS DEPARTMENT OF HEALTH,
May 25, 1978.

Mr. DANTE ROSSI,
Officer-In-Charge, Immigration and Naturalization Services,
St. Thomas, Virgin Islands.

DEAR MR. ROSSI: Governor Juan Luis has requested that I forward to you the physician personnel needs of the Department of Health. These positions are listed as an attachment and are presented by island, position and specialty.

In previous correspondence from both the Attorney General and this Office, we have fully outlined the present situation of available medical services to the residents of the Virgin Islands, which is becoming critical due to the new Immigration Act. Presently, the staffing in our emergency room area is less than two-thirds; pediatric services are functioning with one-fifth of the necessary physician staff; and our Community Health Outreach Programs' staffing is 50%. It becomes readily apparent that foreign physicians are indispensable to the Virgin Islands health delivery system.

Your usual cooperation will be greatly appreciated.

Sincerely,

JOHN S. MOORHEAD, M.D., MPH,
Acting Commissioner of Health.

Enclosure.

PHYSICIAN NEEDS—DEPARTMENT OF HEALTH

ST. THOMAS, VIRGIN ISLANDS

Public health physicians.....	8	General practitioners.....	7
House physicians.....	4	Pediatricians.....	3
Staff physicians.....	4	Urologist.....	1
		Nephrologist.....	1
Total	16	Internist (Cardiologist).....	4
		Total	16

NOTE. Listing is prepared by division and specialty with a total of 16 physicians.

ST. CROIX, V.I.

Public health physicians.....	9	General practitioners.....	11
House physicians.....	5	Psychiatrists.....	2
Staff physicians.....	6	Pediatricians.....	4
		OB-GYN.....	2
Total	20	Dental consultant.....	1
		Total	20

NOTE. Listing is prepared by division and specialty with a total of 20 physicians.

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES,
DEPARTMENT OF HEALTH,
May 26, 1978.

Attention: Mr. Louis Hassell, Immigration Examiner.

Mr. DANTE ROSSI,
Officer in Charge, Immigration and Naturalization Services, Charlotte Amalie,
St. Thomas, Virgin Islands.

DEAR MR. ROSSI: Attached, as requested, is a complete list of all the doctors bonded by the Virgin Islands Department of Health, the area of medicine they are practicing in, their position titles and the island on which they are assigned to work.

Sincerely,

ROY L. SCHNEIDER, M.D.,
Commissioner of Health.

Enclosure.

Bonded doctors—(H-1) Virgin Islands Department of Health

St. Thomas, V.I.		Area of medicine
Name and position title:		
Payle Maynard, M.D., Physician.....		Research and teaching (general medicine).
Chander Rajani, M.D., Physician.....		Research and teaching (general medicine) (Public Health Service).
St. Croix, V.I.		
Maximo Lillido, M.D., House physician.....		General medicine.
Albert Clairmont, M.D., House physician.....		General medicine.
1980 update:		
No. H-1.....		St. Thomas.
No. H-1.....		St. Croix.

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES,
DEPARTMENT OF HEALTH,
June 13, 1978.

MR. DANTE ROSSI,
Officer-In-Charge, Immigration and Naturalization Service, Federal Building,
St. Thomas, Virgin Islands.

DEAR MR. ROSSI: The following summary is attached for physician personnel minimum demands of the Department. U.S. citizens will always be given preference but the extremity of our salary bind forces us to consider aliens.

There are five (5) physicians with H-1 visas in the Virgin Islands; three (3) for St. Thomas and two (2) for St. Croix. In addition there are six (6) funded but unfilled positions for physicians in St. Thomas and nine (9) in St. Croix.

Permission is urgently requested to acquire these fifteen from any source.

Sincerely,

ROY L. SCHNEIDER, M.D.,
Commissioner of Health.

Enclosure.

	Filled	Vacant	New
St. Thomas-St. John:			
Staff physician III.....	18	4	
Staff physician II.....	1		
House physician.....	3		
Physician associates.....	2		
Pediatrician.....	5	1	
Public health house physician.....	1		
Staff physician/obstetrician.....	1		
Physician.....	1		
Public health house physician III.....	3	1	
Total.....	42	6	0
1980 update.....		11	
St. Croix:			
Physician III.....	1	1	
Physician II.....	5		
Public health physician III.....	4	2	1
Public health physician II.....	1	1	
Obstetrician.....	2		
Pediatrician.....	2	1	
Staff physician.....	19	1	
House physician.....	8	2	
Total.....	42	8	1
1980 update.....		14	

Note: 19 applications submitted and pending in St. Croix by foreign medical graduates. 50 applications submitted and pending in St. Thomas by foreign medical graduates.

THE VIRGIN ISLANDS OF THE UNITED STATES,
OFFICE OF THE GOVERNOR,
Charlotte Amalie, St. Thomas, September 13, 1978.

HON. JAMES O. EASTLAND,
Chairman, Subcommittee on Immigration, U.S. Senate, Senate Building, Washington, D.C.

DEAR SENATOR EASTLAND: Your interest and assistance is requested in considering a problem peculiar to the Virgin Islands in regards to obtaining foreign doctors for employment in the medical facilities.

We are challenged with a shortage of physician manpower in the Virgin Islands because of several reasons. There is a low salary paid for government employment which is not competitive with those on the mainland. Until recently, the solution has been to employ qualified physicians available from South-east Asia or other foreign countries. Recent legislation has closed this avenue because of a more adequate number of physicians in the U.S. as a result of an increase in the number of recent graduates. Nevertheless, these graduates will not consider the low salaries paid in the Virgin Islands.

The government hospitals in the Virgin Islands are the only acute care facilities available to the islands' population, visitors from adjacent islands and the tourist population. The last group can reach 16,000 on peak tourist days during the winter. Moreover, because of many socio-economic factors, most of the public health services are provided to a large number of citizens by the Department of Health.

My office has designated the Lieutenant Governor, the Attorney General and the Commissioner of Health to make the contacts necessary to assist in resolving this problem. The U.S. Immigration Service in the Virgin Islands, Puerto Rico and Washington, have declared that they are powerless to modify the law. They have advised us that the only possible source of relief is a waiver for the territory by congressional action.

We request that you consider initiating steps which will permit the Virgin Islands to continue to recruit foreign qualified physicians pending improvement of the economic situation in the Virgin Islands which may enable us to increase salaries for professionals.

Your favorable cooperation and advice in this problem is appreciated. I am available to discuss this problem with you or your staff at any time.

Sincerely,

JUAN LUIS, Governor.

THE VIRGIN ISLANDS OF THE UNITED STATES,
OFFICE OF THE GOVERNOR,
Charlotte Amalie, St. Thomas, February 2, 1979.

MR. RICHARD R. SPURLOCK,
Officer in Charge, U.S. Immigration Office, Federal Government, St. Thomas, Virgin Islands.

DEAR MR. SPURLOCK: Recruitment is a continuing problem in maintaining adequate medical staff in the facilities of the Health Department of the Virgin Islands. The remoteness of the area, limited cultural outlets, high cost of living and low salaries combine to make employment unattractive to professionals on the mainland. Even in nearby Puerto Rico comparative cost of living expenses and the size of the Virgin Islands contribute to the low level of inducement to professionals in all settings including medical opportunities to come here.

On this account the Virgin Islands Department continues to request exemptions from immigration limitations in the employment of foreign national physicians. The Department has been advised that a liberal interpretation of the current law restricting foreign physicians to teaching and research has been circulated at certain levels in the Legislative branches in Washington, D.C.

We are at a crisis point for medical personnel. Particularly, we now have two (2) physicians here from Canada who would like assistance in remaining here.

Sincerely,

JUAN LUIS, Governor.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
PUBLIC HEALTH SERVICE,
HEALTH RESOURCES ADMINISTRATION,
Hyattsville, Md., June 23, 1980.

HON. ELIZABETH HOLTEMAN,
Chairwoman, Subcommittee on Immigration, Refugees and International Law,
Committee on the Judiciary, House of Representatives, Washington, D.C.

DEAR MS. HOLTEMAN: Thank you for your letter of May 20, 1980.

I am pleased to submit for the record responses to the eight questions that were enclosed with your letter and made necessary by the unanticipated time constraints at the time of the May 14 hearing on H.R. 7118 related to Foreign Medical Graduates.

Please let me know if I can be of further assistance.

Sincerely yours,

HENRY A. FOLEY, Ph.D.,
Administrator.

Enclosure.

1. What is the definition of a health manpower shortage area?

A health manpower shortage area is a geographic area, population group, or facility for which the available and accessible supply of specific types of health practitioners is very low relative to the size and needs of its service population, as determined using the criteria defined in regulations on the designation of health manpower shortage areas. (These regulations were published in the Federal Register of January 10, 1978, in response to statutory requirements contained in section 332 of the Public Health Service Act. A copy of the regulations are attached.)

2. To what extent are geographic limitations taken into consideration in determining health manpower shortage areas?

HMSA's may be geographic areas, population groups, or facilities. For all designations, it must be demonstrated that access to resources or services in the vicinity and in contiguous areas is limited by geographic factors (such as excessive distance) or by other types of barriers. In geographic area designations, distance and travel time to available health manpower are also taken into account, as they are in determining what constitutes a rational service area. A 30 minute travel time is used in designation of primary medical care and pharmacy shortage area; 40 minutes is used for designations of other types of manpower.

3. Is there any prohibition on the assignment of National Health Service Corps to inner city hospitals?

No. There is no prohibition for the assignment of National Health Service Corps to inner city hospitals. The statutory authority provides that corp personnel must be assigned to a Health Manpower Shortage Area (HMSA) which may be an area, a population group or a facility. Therefore, the hospital would have to be (or be in) a designated HMSA; and, in addition, the assignment of NHSC personnel to the hospital would be subject to statutory priority criteria.

4. How many NHSC personnel are located in New York City, New York State?

There are 46 NHSC personnel in New York City, including 18 physicians, 4 dentists, 7 nurse practitioners, 10 physician assistants and 7 other health care personnel. In New York there are 128 NHSC personnel including 60 physicians, 8 dentists, 12 nurse practitioners, 25 physician assistants and 14 other health care personnel.

5. When does a Corps person fulfill his commitment to the NHSC?

A. Scholarship recipients incur one year of service obligation for each year of Scholarship support. The minimum service obligation is 2 years and the maximum is 4 years. Service may be performed either as a Federal employee (Civil Service or Commissioned Corps of the PHS) or as a non-Federal private practitioner. Service periods must be performed as full-time clinical practitioners in health manpower shortage areas designated under section 332 of the PHS Act for their profession or specialty.

The law concerning service fulfillment (section 752 of the Public Health Service Act, as amended; 42 U.S.C. 294u) provides that Scholarship recipients who are students of medicine, osteopathy, and dentistry, begin their service obligation when they complete the training required for their degree. However, at their request, the service period may be deferred for up to three years to complete an internship, residency, or other advanced clinical training. Periods for longer than three years may be given, but only for specialties needed by the NHSC. The Scholarship Program is currently deferring Scholarship recipients for 4 years to complete specialty training in general psychiatry and obstetrics-gynecology. Under current legislation, no period of training deferment may count toward fulfilling the Scholarship obligation.

6. Where are NHSC personnel most needed—in rural or urban areas?

Seventy percent of all designated primary care manpower shortage areas are in nonmetropolitan areas. However, rural areas contain slightly less than 50% of the population of all designated primary care shortage areas. Hence, the number of NHSC personnel needed in rural and urban areas appears to be approximately equal, based on currently designated areas.

7. Should the NHSC role be enlarged in the urban setting?

Prior to 1978 few Corps members were assigned to urban areas. Since that time approximately one-third of all new assignees have been placed in urban settings. We anticipate that the initiative to place NHSC members in urban locations will continue.

8. Do you feel the Federal Government should play a greater role in determining the placement of U.S. medical graduates for training?

A. The Administration's program for assuring availability of numbers of professionals necessary to meet the Nation's most pressing health service needs concentrates on alleviating problems of geographic maldistribution through service commitment scholarships and the National Health Service Corps field placement program. It concentrates on addressing the shortage of primary care personnel through support of primary care training programs.

Our health professions program is part of a broader strategy to be complemented by other Administration initiatives such as reimbursement reforms and expanded primary care delivery programs. There is a possibility that the numbers of physicians going to underserved areas will increase as the supply of doctors grows over the next few years. We will study location trends closely and reappraise our strategies for meeting the needs of underserved areas based on this experience.

Some States have supported their own programs to improve the distribution of health professionals. The Administration favors authorizing the Secretary to enter into cooperative agreements with those States to provide for closer accord in the development of plans for reducing geographic maldistribution, using a State health professional placement program as well as the National Health Service Corps. These and other types of joint arrangements should help increase State input in health professions planning and management.

Because physicians in graduate medical education programs provide some patient care as part of the residency training process, the placement of physicians for graduate training does affect availability of health services in the areas served. To assure high quality care to underserved populations, however, we favor the assignment to shortage areas of physicians who have already completed part or all of their residency training.

The Department's Graduate Medical Education National Advisory Committee is currently studying physician specialist requirements in the U.S. and related questions concerning the training of those specialists. Later this year the Committee plans to complete a report on its findings to date, including recommendations on how best to assure a balance of trainees in residency programs in the future. Geographic distribution of training programs can be expected to be among the issues addressed.

**TUESDAY, JANUARY 10, 1978
PART II**



**DEPARTMENT OF
HEALTH,
EDUCATION,
AND WELFARE**

Public Health Service

•

**HEALTH MANPOWER
SHORTAGE AREAS**

Criteria for Designation

RULES AND REGULATIONS

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[4116-23]

Title 42—Public Health

CHAPTER I—PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

PART 3—DESIGNATION OF HEALTH MANPOWER SHORTAGE AREAS

Establishment of Criteria

AGENCY: Public Health Service, HEW.

ACTION: Interim-Final Regulations.

SUMMARY: These regulations establish criteria for designation of health manpower shortage areas pursuant to section 332 of the Health Professions Educational Assistance Act of 1976. Entities in these areas will be eligible to apply for assignment of National Health Service Corps personnel. These areas will also be eligible service areas for Public Health Service scholarship and loan repayment programs, and will be used in connection with other Public Health Service programs.

DATES: These regulations are effective immediately. As discussed below, comments on the regulations are invited, but must be received on or before February 24, 1978 in order to be considered.

ADDRESSES: Written comments, preferably in triplicate, should be addressed to the Director, Bureau of Health Manpower, Health Resources Administration, Center Building, 3700 East West Highway, Hyattsville, Md. 20782. All comments received will be available for public inspection and copying at the Office of Program Operations, Bureau of Health Manpower, Room 4-22, at the above address, weekdays (Federal holidays excepted), between the hours of 8:30 a.m. and 5 p.m.

FOR FURTHER INFORMATION CONTACT:

Richard C. Lee, Chief, Shortage Area Designation Section, Manpower Analysis Branch, Bureau of Health Manpower, Room 4-41, at the above address, telephone 301-436-6764.

SUPPLEMENTARY INFORMATION:

On October 12, 1976, a new section 332 entitled "Designation of Health Manpower Shortage Areas" was added to the Public Health Service Act (42 U.S.C. 254e), by Pub. L. 94-484, the Health Professions Educational Assistance Act of 1976. This section requires that the Secretary of Health, Education, and Welfare establish, by regulation, criteria for the designation of health manpower shortage areas and, subsequently designate areas and, subsequently designate areas and, subsequently designate areas based upon these criteria. Public or nonprofit entities in (or with a demon-

strated interest in), the areas designated pursuant to these criteria will be eligible to apply for the assignment of members of the National Health Service Corps to provide health services in or to the areas (see section 333(a) of the Public Health Service Act). These areas will also be the eligible service areas for PHS scholarship and loan repayment programs (see sections 735(c), 741(f), 751, and 759 of the Act). The areas designated under these regulations thus will supersede the lists of areas previously designated under sections 329(b) and 741(f) of the Public Health Service Act. These areas will also be used for other purposes under the Public Health Service Act (see sections 788(a), 788(f), 822 of the Act).

As required by section 332(b), the regulations set forth below include criteria for the designation of area, population groups, medical facilities, and other public facilities as health manpower shortage areas. As also required, practitioner-to-population ratios, infant mortality rates, health status, access to health services, other indicators of need, and the percentage of physicians who are foreign medical graduates have been considered as factors in establishing these criteria.

The criteria for designation of health manpower shortage areas have been developed separately according to the type of health manpower for which a shortage may be indicated. The types of manpower shortage areas for which criteria are being included at the present time are:

- A. Areas with shortages of primary medical care manpower;
- B. Areas with shortages of dental manpower;
- C. Areas with shortages of psychiatric manpower;
- D. Areas with shortages of vision care manpower;
- E. Areas with shortages of podiatric manpower;
- F. Areas with shortages of pharmacy manpower; and
- G. Areas with shortages of veterinary manpower.

The above types of health manpower are those which are currently available for placement by the National Health Service Corps (as a result of recruitment activities and scholarship programs), and/or are currently eligible for health professions student loan cancellation and repayment programs under the Public Health Service Act. The possibility that there exist significant shortages of other types of health manpower is currently being explored, and criteria for other types of health manpower shortage may be developed in the future and included within part 3.

Criteria contained in the regulations have been chosen so as to identify geographic areas, population groups, and

facilities with severe manpower shortages; shortages of a severity that justify the use of Federal resources for their alleviation. These criteria do not represent adequacy levels, so there may be many areas which do not meet these criteria and yet have inadequate health manpower. The Department has prepared a report setting forth, in more detail, the statistical and programmatic basis for the criteria included in part 3. Interested persons can obtain a copy of that report at the address listed above.

The criteria include methods for comparing the degree of shortage of any two areas designated as having a particular type of shortage. This is required for implementation of section 333(c)(1) of the act, which requires that the Secretary give priority to those applications for National Health Service Corps personnel of persons result in assignment of Corps personnel to "an area, population group, medical facility, or other public facility with the greatest health manpower shortage, as determined under criteria established under section 332(b)."

The regulations also spell out the procedures for designation of areas using these criteria, including consideration of the recommendations of health systems agencies, State health planning and development agencies, and Governors, as required by the statute.

The Department has prepared a preliminary list of possible health manpower shortage areas for review by appropriate agencies under the regulations. Immediately upon publication of these regulations, the review procedures detailed therein will be initiated. In approximately 90 days, the resulting first list of health manpower shortage areas under section 332 will be designated and published in the Federal Register. As noted in the regulations, any agency or individual may recommend the designation of a particular geographic area, population group, or facility as a health manpower shortage area. Such recommendations may be sent to the Chief, Shortage Area Designation Section, Manpower Analysis Branch, at the address above.

In light of the statutory deadlines for publication of these regulations and for the designation of areas, and the fact that implementation of the Public Health Service Act is dependent upon these designations, the Secretary has determined that good cause exists for the notice, public participation and de-layed effective date requirements of 5 U.S.C. 553 not to be followed in connection with the publication of part 3. However, in accordance with the Secretary's policy in obtaining public participation, comments will be accepted on this interim rule at the above listed

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address for a 45-day period. After consideration of these comments, the Secretary will republish the rules in part 5, revised as appropriate based upon consideration of the public comments received.

Accordingly, 42 CFR is amended, effective immediately, by adding thereto a new part 5 as set forth below.

NOTE.—The Department of Health, Education, and Welfare has determined that this document does not contain a major proposal requiring preparation of an Inflation Impact Statement under Executive Order 11821 and OMB Circular A-197.

Dated: September 26, 1977.

JULIUS B. RICHMOND,

Assistant Secretary for Health.

Approved: December 21, 1977.

JOSEPH A. CALIFANO, Jr.,

Secretary.

- Sec.**
5.1 Purpose.
5.2 Definitions.
5.3 Procedure for designation of health manpower shortage areas.
5.4 Notification of designation.
Appendix A. Criteria for Designation of Areas Having Shortages of Primary Medical Care Manpower.
Appendix B. Criteria for Designation of Areas Having Shortages of Dental Manpower.
Appendix C. Criteria for Designation of Areas Having Shortages of Psychiatric Manpower.
Appendix D. Criteria for Designation of Areas Having Shortages of Vision Care Manpower.
Appendix E. Criteria for Designation of Areas Having Shortages of Podiatric Manpower.
Appendix F. Criteria for Designation of Areas Having Shortages of Pharmacy Manpower.
Appendix G. Criteria for Designation of Areas Having Shortages of Veterinary Manpower.
AUTHORITY: Section 215 of the Public Health Service Act, 58 Stat. 806 (42 U.S.C. 216); Section 332 of the Public Health Service Act, 90 Stat. 2770-2773 (42 U.S.C. 254e).

§ 5.1 Purpose.
 Section 332(b) of the Public Health Service Act (42 U.S.C. 254e) requires the Secretary to establish criteria for the designation of geographic areas, population groups, medical facilities, and other public facilities, in the States, as health manpower shortage areas. The purpose of this Part is to comply with this requirement.

§ 5.2 Definitions.

For purposes of this Part:
 (a) "Act" means the Public Health Service Act, as amended.

(b) "Health manpower shortage area" means (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services) which the Secretary determines

has a shortage of health manpower, (2) a population group which the Secretary determines has such a shortage, or (3) a public or nonprofit private medical facility or other public facility which the Secretary determines has such a shortage.

(c) "Health service area" means a health service area whose boundaries have been designated by the Secretary, pursuant to section 1511 of the Act, for purposes of health planning activities.

(d) "Health systems agency" or "HSA" means the health systems agency designated, pursuant to section 1515 of the Act, to carry out health planning activities for a given health service area.

(e) "Medical facility" means a facility for the delivery of health services and includes: (1) a community health center, public health center, outpatient medical facility, or community mental health center; (2) a hospital, State mental hospital, facility for long-term care, or rehabilitation facility; (3) a migrant health center, or an Indian Health Service facility; (4) facilities for delivery of health services to U.S. penal and correctional institutions under section 323 of the Act or to State correctional institutions; (5) a Public Health Service medical facility used in connection with the delivery of health services under sections 321, 322, 324, 326, 328, or Part D of Title III of the Act; or (6) other Federal medical facilities.

(f) "Metropolitan area" means an area which has been designated by the Office of Management and Budget as a standard metropolitan statistical area (SMSA). All other areas are "non-metropolitan areas".

(g) "Poverty level" means the poverty level as defined by the Bureau of the Census, using the poverty index adopted by a Federal Interagency Committee in 1969, and updated each year to reflect changes in the Consumer Price Index.

(h) "Secretary" means the Secretary of Health, Education, and Welfare and any other officer or employee of the Department of Health, Education, and Welfare to whom the authority involved has been delegated.

(i) "State" includes, in addition to the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Northern Mariana Islands, the Virgin Islands, Guam, American Samoa, and the Trust Territory of the Pacific Islands.

(j) "State health planning and development agency" or "HPDA" means the State health planning and development agency designated pursuant to section 1521 of the Act.

§ 5.3 Procedure for designation of health manpower shortage areas.

(a) **General.** (1) Using data available to the Department and based upon the

criteria in the Appendices to this Part, the Department will prepare a preliminary list (by State and health service area) of possible health manpower shortage areas. Relevant portions of this list will then be forwarded to the appropriate HSA, SHPDA, and Governor with a request that they review the preliminary list and offer their recommendations, if any, within 60 days, as to which geographic area, population groups, and facilities in areas under their jurisdiction should be designated.

(2) In addition, any agency or individual may recommend to the Secretary the designation of a particular geographic area, population group or facility as a health manpower shortage area. Such individual recommendations will be forwarded to the appropriate HSA, SHPDA, and Governor, for review and recommendation within 30 days.

(3) In each case where the designation of a public facility (including a Federal medical facility) is under consideration, the Secretary will give written notice of such proposed designation to the chief administrative officer of such facility and request comments within 30 days with respect to such designation.

(4) After considering these recommendations and comments, the Secretary will designate health manpower shortage areas and publish a list of such areas in the *Federal Register*.

(b) **Revisions.** (1) The list of designated areas will be reviewed annually and revised, as necessary, in accordance with the procedures outlined in paragraph (a) of this section. The revised list will then be published in the *Federal Register*.

(2) During the period between revisions, requests for specific revisions relating to particular geographic areas, population groups, or facilities will be reviewed on a case-by-case basis, in accordance with the procedures in paragraphs (a) (2) and (3) of this section. A notice will be published periodically in the *Federal Register* updating the list of designated areas based upon such requests.

§ 5.4 Notification of designation.

The Secretary will give written notice of the designation (or withdrawal of designation) of a health manpower shortage area, not later than 60 days from the date of such designation (or withdrawal of designation) to:

(a) The Governor of each State in which the area, population group, medical facility, or other public facility so designated is in whole or in part located.

(b) Each health systems agency for a health service area which includes all or any part of such area, population group, medical facility, or other public facility so designated.

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(c) The State health planning and development agency for each State in which the area, population group, medical facility, or other public facility so designated is in whole or in part located.

(d) Appropriate public or nonprofit private entities which are located in or which have a demonstrated interest in the area as designated.

APPENDIX A.—Criteria for Designation of Areas Having Geographic or Primary Medical Care Manpower

PART I.—GEOGRAPHIC AREAS

A. Criteria

A geographic area will be designated as having a shortage of primary medical care manpower if the following three criteria are met:

1. The area is a rational area for the delivery of primary medical care services.

2. One of the following conditions prevails within the area:

(a) The area has a population-to-primary care physician ratio of at least 3,600:1; or
(b) The area has a population-to-primary care physician ratio of less than 3,600:1 but greater than 3,000:1 and has either unusually high need for primary medical care services or insufficient capacity of existing primary care providers.

3. Primary medical care manpower in contiguous areas are overutilized, excessively dispersed, or inaccessible to the population of the area under consideration.

B. Methodology

In determining whether an area meets the criteria established by paragraph A of this Part, the following methodology will be used:

1. **Rational Areas for the Delivery of Primary Medical Care Services.** (a) The following areas will be considered rational areas for the delivery of primary medical care services:

(i) A county or a group of contiguous counties whose population centers are within 30 minutes travel time of each other.

(ii) A portion of a county, or an area made up of portions of more than one county, whose population, because of topography, market or transportation patterns, distinctive population characteristics or other factors, has limited access to contiguous area resources as measured generally by a travel time greater than 30 minutes to such resources.

(iii) Established neighborhoods and communities within urbanized areas which display a strong self identity (as indicated by a homogeneous socioeconomic or demographic structure and/or a tradition of interaction or interdependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 35,000.

(b) The following distances will be used to estimate distances corresponding to 30 minute travel time:

(i) Under normal conditions with primary roads available: 20 miles.

*Primary medical care manpower as used here includes nurse practitioners and physician assistants as well as primary care physicians.

(ii) In mountainous terrain or in areas with only secondary roads available: 15 miles.

(iii) In flat terrain or in areas connected by interstate highway: 25 miles.

Within inner portions of metropolitan areas, the large variations in the scope of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In these areas, information on the public transportation system will be used to determine the distance corresponding to 30 minutes travel time.

3. **Population Count.** The population count used will be the total permanent resident civilian population of the area, excluding

inmates of institutions, with the following adjustments, where appropriate:

(a) Adjustments to the population for the differing health service requirements of various age-sex population groups will be computed using the table below of visit rates for 13 age-sex population cohorts. The total expected visit rate will first be obtained by multiplying each of the 13 visit rates in the table by the size of the area population within that particular age-sex cohort and adding the resultant 13 visit figures together. This total expected visit rate will then be divided by the U.S. average per capita visit rate of 8.1, to obtain the adjusted population for the area.

AGE GROUPS

Sex	Under 5	5-14	15-24	25-44	45-64	65 and over
Male	7.8	3.8	3.3	1.8	4.7	8.4
Female	9.4	3.3	3.3	2.4	5.4	9.9

(b) The effect of transient populations on the need of an area for manpower will be taken into account as follows:

(i) Seasonal tourist populations will be included in an area's population with a weight of 0.5, as computed according to the following formula: Effective tourist population = $0.5 \times (\text{proportion of year tourists are present in area}) \times (\text{average daily number of tourists during portion of year that tourists are present})$.

(ii) The migrant population will be included in an area's population, as computed according to the following formula: Effective migrant population = $(\text{proportion of year migrants are present in area}) \times (\text{average daily number of migrants during portion of year that migrants are present})$.

3. **Counting of Primary Care Practitioners.** (a) All non-Federal doctors of medicine (M.D.) and doctors of osteopathy (D.O.)

providing direct patient care who practice principally in one of the four primary care specialties—general or family practice, general internal medicine, general pediatrics, and obstetrics and gynecology—will be counted. Those physicians engaged solely in administration, research, and teaching will be excluded. Hospital-based primary care physicians will be included to the extent that they provide ambulatory services and first-contact care. Adjustments for the following factors will be made in counting physicians, however:

(i) Interns and residents will be counted as 0.5 full-time equivalent (FTE) physicians to reflect the fact that a large portion of their time is spent in training.

(ii) Foreign medical graduates (i.e., graduates of medical programs outside the U.S.) who do not have a stable immigration status (i.e., U.S. citizenship or a permanent visa) will be excluded from physician counts since their future availability to help provide medical care to the area's population is uncertain.

(iii) Foreign medical graduates who have a stable immigration status, but are not fully licensed to practice medicine will be counted as 0.5 FTE physicians to reflect their practice limitations and time spent in training.

(b) Practitioners who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who are available to the population of an area only on a part-time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as

the standard for determining full-time equivalents in such cases. For practitioners working less than a 40-hour week, every four (4) hours (or 1/5) spent providing patient care, in either ambulatory or inpatient settings, will be counted as 0.1 FTE.

(c) Physicians providing patient care 40 or more hours a week will be counted as 1.0 FTE physician.

(d) In some cases, physicians located within an area may not be accessible to the population of the area under consideration. Allowances for physicians with restricted practices will be made, on a case-by-case basis. Examples of such restricted practices include refusal to accept certain types of patients or to accept Medicaid reimbursement.

(e) Nurse practitioners and physician assistants also make important contributions to the provision of primary medical care services. While national equivalency figures for taking the availability of nurse practitioners and physician assistants into account are not included here because of variations in their responsibilities across States and regions, their contribution to the supply of primary care services in individual areas will be considered where appropriate data are available.

4. **Determination of Unusually High Needs for Primary Medical Care Services.** An area will be considered as having unusually high needs for primary medical care services if at least one of the following criteria is met:

(a) The area has more than 100 births per 1,000 women aged 15-44, or more than 40 births per 1,000 women aged 15-17.

(b) The area has more than 20 infant deaths per 1,000 live births.

(c) More than 30 percent of the population (or of all households) have incomes below the poverty level.

5. **Determination of Insufficient Capacity of Existing Primary Care Providers.** An area's existing primary care providers will be considered to have insufficient capacity if at least two of the following criteria are met:

(a) More than 8,000 office or outpatient visits per year per FTE primary care physician serving the area.

(b) Unusually long waits for appointments for routine medical services (i.e., more than 7 days for established patients and 14 days for new patients).

(c) Excessive average waiting time at primary care providers (longer than one hour

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where patients have appointments or two where where patients are treated on a first-come, first-served basis.

(d) Evidence of excessive use of emergency room facilities for routine primary care.

(e) A substantial proportion (4 or more) of the area's physicians do not accept new patients.

(f) Abnormally low utilization of health services, as indicated by an average of 3.9 or less office visits per year on the part of the area's population.

8. **Contiguous Area Considerations.** Primary care manpower in areas contiguous to an area being considered for designation will be considered consecutively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in each contiguous area.

(a) Primary care manpower in the contiguous area are more than 30 minutes travel time from the center of the area being considered for designation (measured in accordance with paragraph 3.(b) of this Part I).

(b) Contiguous area population-to-PTC primary care physician ratios are in excess of 1,000:1, indicating that contiguous areas cannot be expected to help alleviate the shortage situation in the area being considered for designation.

(c) Primary care manpower in contiguous areas are inaccessible to the population of the area under consideration because of specified access barriers, such as:

(1) Significant differences between the demographic (or socio-economic) characteristics of the area under consideration and those of the contiguous area, indicating that the population of the area under consideration may be effectively isolated from nearby resources. Such isolation could be in disease, for example, by an unusually high proportion of non-English-speaking persons.

(2) The area's population lacks economic accessibility to contiguous area resources. For those areas where a very high proportion of the population is poor (i.e., where more than 50 percent of the population or of the households have incomes below the poverty level), failure of a substantial majority of contiguous area providers to accept Medicaid will be taken to indicate such economic inaccessibility. Contiguous areas where the ratio of poverty population to number of primary care physicians accepting Medicaid is higher than 1,000:1 will then be assumed to have no access capacity which can relieve the shortage in the area under consideration.

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area, designated as having a shortage of primary medical care manpower, will be determined using the following procedure:

1. **Grouping of Areas.** Designated areas will first be assigned to groups, based on the ratio (R) of population to number of full-time equivalent primary care physicians and the presence or absence of unusually high needs for primary medical care services or insufficient capacity of existing primary care providers, according to the following table:

	High needs or insufficient capacity not indicated	High needs or insufficient capacity indicated
Group 1.....	No physicians or No physician or B < 1,000	
Group 2.....	R > 1,000	1,000 > R > 1,000

	High needs or insufficient capacity not indicated	High needs or insufficient capacity indicated
Group 3.....	1,000 > R > 1,000	1,000 > R > 1,000
Group 4.....	1,000 > R > 1,000	1,000 > R > 1,000

All group 1 areas will be assumed to have a greater shortage than all group 2 areas, all group 2 areas will be assumed to have a greater shortage than all group 3 areas, etc.

2. **Relative Shortage within a Group.** In comparing any two areas within each group as defined above, the area with the larger population will be assumed to have the greater shortage.

PART II—POPULATION GROUPS

A. Criteria.

The following population groups will be designated as having a shortage of primary medical care manpower:

(1) Those American Indians and Alaska Natives who are members of Indian tribes (as defined in section 4(d) of Pub. L. 94-437, the Indian Health Care Improvement Act of 1976).

(2) Other American Indians (as defined in section 4(c) of Pub. L. 94-437), migrant populations, and other population groups within particular geographic areas will be designated if the following criteria are met:

(a) Access barriers prevent the population group from use of the area's primary medical providers (such as refusal of practitioners to accept certain types of patients or refusal to accept Medicaid reimbursement); and

(b) The ratio (R) of the number of persons in the population group to the number of PTC primary care physicians serving the population group, and practicing within 30 minutes travel time of the center of the area where the population group resides, is at least 1,000:1 (1,000:1, where unusually high needs for health services exist in the population group, as determined in accordance with paragraph 3.4 of Part I of this Appendix). The population of the group is to be counted in accordance with paragraph 3.2 of Part I of this Appendix, except that for migrant populations in high impact areas (as defined in section 31(a)(3) of the Act), the average number of migrants in the area during the period of highest impact will be used.

B. Determination of Degree of Shortage

The degree of shortage of a given population group, designated as having a shortage of primary care manpower, will be determined as follows:

1. The population group will first be assigned to a degree-of-shortage grouping as in Paragraph C of Part I of this Appendix, based on the ratio (R) of the group's population to the number of primary care physicians serving it, together with the presence or absence of unusually high needs for primary medical care services among the population group.

2. In comparing any two population groups within a degree-of-shortage grouping, or in comparing a designated population group with a designated area within the same grouping, the area or population group with the larger population will be assumed to have the greater shortage. (In the case of Indian tribes, the population figure used will be that population served by each Indian Health Service (IHS) facility which requires staffing.)

PART III—FACILITIES

A. Federal and State Correctional Institutions

1. **Criteria.** Medium to maximum security Federal and State correctional institutions will be designated as having a shortage of primary medical care manpower if both the following criteria are met:

(a) The institution has at least 300 inmates.

(b) The ratio of the number of inmates per year to the number of PTC primary care physicians serving the institution is at least 1,000:1. (The number of inmates is the number of inmates present at the beginning of the year plus the number of new inmates entering the institution during the year, including those on short sentences who left before the end of the year.)

2. **Determination of Degree of Shortage.** The degree of shortage of a given correctional institution, designated as having a shortage of primary care medical manpower, will be determined as follows:

(a) **Grouping of correctional institutions.** Correctional institutions will first be grouped as follows, based on number of inmates and/or the ratio (R) of inmates to primary care physicians:

Group 1—Institutions with 300 or more inmates and no physician.

Group 2—Institutions with 350-499 inmates and no physician; or with any number of inmates and R > 1,000.

Group 3—Institutions with 1,000 > R > 1,000.

(b) **Relative shortage within a group.** In comparing any two institutions within a given group, the institution with the larger number of inmates will be assumed to have the greater shortage.

B. Public or Non-profit Private Medical Facilities

1. **Criteria.** Public or nonprofit private medical facilities will be designated as having a shortage of primary medical care manpower if:

(a) The facility is providing primary medical care services to an area or population group designated as having a primary care manpower shortage; and

(b) The facility has insufficient capacity to meet the primary care needs of that area or population group.

2. **Methodology.** In determining whether public or nonprofit private medical facilities meet the criteria established by paragraph B.1 of this Part, the following methodology will be used:

(a) **Provision of Services to a Designated Area or Population Group.** A facility will be considered to be providing services to a designated area or population group if either:

(1) majority of the facility's primary care services are being provided to residents of designated primary care manpower shortage areas or to population groups designated as having a shortage of primary care manpower; or

(2) The population within a designated primary care shortage area or population group has reasonable access to primary care services provided at the facility. Such reasonable access will be assumed if the population lies within 30 minutes travel time of the facility and non-physical barriers (relating to demographic and socioeconomic characteristics of the population) do not prevent the population from receiving care at the facility.

Indian Health Service facilities and migrant health centers (as defined in section

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(1)(a)(i) of the Act) are assumed to be meeting this requirement.

(b) *Inefficient capacity to meet primary care needs.* A facility will be considered to have insufficient capacity to meet the primary care needs of a designated area or population group if at least two of the following conditions exist at the facility:

(i) There are more than 8,000 outpatient visits per year per primary care physician on the staff of the facility.

(ii) There is excessive usage of emergency room facilities for routine primary care.

(iii) Waiting time for appointments is more than 7 days for established patients and/or more than 14 days for new patients seeking routine health services.

(iv) Waiting time at the facility is longer than one hour where patients have appointments or two hours where patients are treated on a first-come, first-served basis.

Indian Health Service facilities will be considered to have insufficient capacity if the staffing requirements established by the Indian Health Service are not met.

3. *Determination of Degree of Shortage.* The degree of shortage of a medical facility designated as having a shortage of primary medical care personnel will be determined as follows:

(a) *Grouping of areas.* Medical facilities will be grouped as in Paragraph C of Part I of this Appendix, in the same groupings as the designated area or population group which they serve.

(b) *Relative shortage within a group.* In comparing a facility with other designated facilities, areas, or population groups within the same grouping, the population figure used for the facility shall be that of the population of the designated area or population group which the facility serves. The area, population group, or facility with the larger population or service population will then be assumed to have the greater short- age.

APPENDIX B—CRITERIA FOR DESIGNATION OF AREAS HAVING SHORTAGES OF DENTAL SERVICES

PART I—GENERAL PRINCIPLES

A. Criteria

A geographic area will be designated as having a dental manpower shortage if the following three criteria are met:

1. The area is a rational area for the delivery of dental services.

2. One of the following conditions is prevalent in the area:

(a) The area has a population-to-dentist ratio of at least 8,000:1, or

(b) The area has a population-to-dentist ratio of less than 8,000:1 but greater than 4,000:1 and has either unusually high needs for dental services or insufficient capacity of existing dental providers.

3. Dental manpower in contiguous areas are overutilized, excessively distant, or inaccessible to the population of the area under consideration.

B. Methodology

In determining whether an area meets the criteria established by paragraph A of this Part, the following methodology will be used:

1. *Rational Areas for the Delivery of Dental Services.* (a) The following areas will be considered rational areas for the delivery of dental services:

(i) A county, or a group of several contiguous counties whose population centers are within 60 minutes travel time of each other.

(ii) A portion of a county (or an area made up of portions of more than one county) whose population, because of topography, mode of transportation, industry, distinctive population characteristics, or other factors, has limited access to contiguous areas resources, or measured accessibility by a travel time of greater than 60 minutes to such resources.

(iii) Established neighborhoods and communities within urbanized areas which display a strong self-identity (as indicated by a homogeneous socioeconomic or demographic structure and/or a tradition of interaction or interdependency), have limited interaction with contiguous areas, and which, in general, have a minimum population of 30,000.

(b) The following distances will be used to estimate distances corresponding to 60 minutes travel time: (i) Under normal conditions with primary roads available: 30 miles. (ii) In mountainous terrain or in areas with only secondary roads available: 30 miles.

(iii) In flat terrain or in areas connected by interstate highways: 30 miles.

Within lower portions of metropolitan areas, the large variations in the scope of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In these areas, information on the public transportation system will be used to determine the distance corresponding to 60 minutes travel time.

2. *Population Count.* The population count used will be the total permanent resident civilian population of the area, excluding inmates of institutions, with the following additions to take into account the effect of transient populations, where appropriate: (a) Seasonal tourist populations will be included in an area's population with a weight of 0.5, as computed according to the following formula: Effective tourist population = $S \times (\text{proportion of year tourists are present in area}) \times (\text{average daily number of tourists during portion of year that tourists are present})$.

(b) The migrant population will be included in an area's population, as computed according to the following formula: Effective migrant population = $(\text{proportion of year migrants are present in area}) \times (\text{average daily number of migrants during portion of year that migrants are present})$.

3. *Counting of Dental Practitioners.* (a) All non-Federal dentists providing patient care will be counted, except in those urban areas where it is shown that specialists (those dentists not in general practice or pediatrics) are serving a larger metropolitan area and are not addressing the general dental care needs of the area under consideration.

(b) Full-time equivalent (FTE) figures will be used to reflect productivity differences among dental practices based on the age of the dentists, the number of auxiliaries employed, and the number of hours worked per week. In general, the number of FTE dentists will be computed using weights obtained from the matrix in Table 1, which is based on the productivity of dentists at various ages, with different numbers of auxiliaries, or measured with the services productivity of all dentists. For the purposes of these determinations, an auxiliary is defined as any non-dentist staff employed by the dentist to assist in operation of the practice.

TABLE 1.—Equivalency weights, by age and number of auxiliaries

	<35	35-39	40-44	45+
No auxiliaries	.30	.50	.50	.40
1 auxiliary	1.20	.80	.50	.40
2 auxiliaries	1.10	1.20	1.00	.70
3 auxiliaries	1.40	1.30	1.00	1.00
4 or more auxiliaries	1.40	1.40	1.30	1.30

If information on the number of auxiliaries employed by the dentist is not available, Table 1 may be used to compute the number of fulltime equivalent dentists.

TABLE 2.—Equivalency weights, by age

Age	<35	35-39	40-44	45+
Equivalency weights	1.10	.50	.70	.50

The number of equivalent dentists within a particular age group (or age/auxiliary group) will be obtained by multiplying the number of dentists in that group by its corresponding equivalency weight. The total number of equivalent dentists within an area is then computed as the sum of these dentists within each age (or age/auxiliary) group.

(c) The equivalency weights specified in Tables 1 and 2 assume that dentists within a particular age group are working full-time (40 hours per week). Where appropriate data are available, adjusted equivalency figures for dentists who are working less than full-time are a reduced practice due to infirmity or other limiting conditions or who are available to the population of an area only on a part-time basis will be used to reflect the reduced availability of such dentists. In computing such equivalency figures, every 4 hours (or 1/5 day) spent in the dental practice will be counted as 0.1 FTE, except that such dentists working more than 40 hours a week will be counted as 1.0. The count obtained for a particular age group of dentists will then be multiplied by the appropriate equivalency weight from Table 1 or 2 to obtain a full-time equivalent figure for dentists within that particular age or age/auxiliary category.

4. *Determination of Unusually High Needs for Dental Services.* An area will be considered as having unusually high needs for dental services if at least one of the following criteria is met:

(a) More than 30 percent of the population (or of all households) have incomes below the poverty level.

(b) The area does not have a fluoridated water supply.

5. *Determination of Insufficient Capacity of Existing Dental Care Providers.* An area's existing dental care providers will be considered to have insufficient capacity if any of the following criteria are met:

(a) More than 8,000 visits per year per FTE dentist serving the area.

(b) Unusually long waits for appointments for routine dental services (i.e., more than 6 weeks).

(c) A substantial proportion (1/3 or more) of the area's dentists do not accept new patients.

6. *Contiguous Area Considerations.* Dental manpower in areas contiguous to an area being considered for designation will be considered excessively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in such contiguous areas:

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(a) Dental manpower in the contiguous area is more than 40 minutes travel time from the center of the area being considered for designation (measured in accordance with paragraph B.1.(b) of this Part).

(b) Contiguous area population-to-PTE dentist ratios are in excess of 1,000:1, indicating that resources in contiguous areas cannot be expected to help alleviate the shortage situation in the area being considered for designation.

(c) Dental manpower in contiguous areas are inaccessible to the population of the area under consideration because of specified access barriers, such as:

(1) Significant differences between the demographic (or socioeconomic) characteristics of the area under consideration and those of the contiguous area, indicating that the population of the area under consideration may be effectively isolated from nearby resources. Such isolation could be, for example, by an unusually high density of non-English-speaking persons.

(2) The area's population lacks economic resources, particularly those areas where a very high proportion of the population is poor (i.e., more than 50 percent of the population or of the households have incomes below the poverty level).

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area, designated as having a shortage of dental manpower, will be determined using the following procedures:

1. Grouping of Areas. Designated areas will first be assigned to groups, based on the ratio (R) of population to number of full-time equivalent dentists and the presence or absence of unusually high needs for dental service or insufficient capacity of existing dental care providers, according to the following table:

	High needs or insufficient capacity not indicated	High needs or insufficient capacity indicated
Group 1	No dentists	No dentists or R < 500
Group 2	R < 500	500 < R < 1,000
Group 3	500 < R < 1,000	1,000 < R < 2,000
Group 4	2,000 < R < 4,000	4,000 < R < 8,000

All group 1 areas will be assumed to have a greater shortage than all group 2 areas; all group 2 areas will be assumed to have a greater shortage than all group 3 areas, etc. Relative Shortage within a Group.

PART II—POPULATION GROUPS

A. Criteria

The following population groups will be designated as having a shortage of dental manpower:

1. Those American Indians and Alaska Natives who are members of Indian tribes (as defined in section 4(d) of Pub. L. 94-437, the Indian Health Care Improvement Act of 1976).

3. Other American Indians (as defined in section 4(c) of Pub. L. 94-437), migrant populations, and other population groups within particular geographic areas will be designated if both of the following criteria are met:

(a) Access barriers prevent the population group from use of the area's dental providers (such as refusal of practitioners to accept certain types of patients); and

(b) The ratio (R) of the number of persons in the population group to the number of PTE dentists serving the population group, and practicing within 40 minutes travel time of the center of the area where the population group resides, is at least 5,000:1 (4,000:1, where unusually high needs for dental services exist in the population group, as determined in accordance with paragraph B.4 of Part I of this Appendix). The population of the group is to be counted in accordance with paragraph B.3 of Part I of this Appendix, except that for migrant populations in high impact areas (as defined in section 31(k)(8) of the Act), the average number of migrants in the area during the period of highest impact will be used.

B. Determination of Degree of Shortage

The degree of shortage of a given population group, designated as having a shortage of dental manpower, will be determined as follows:

1. The population group will first be assigned to a degree of shortage grouping as stated in paragraph C of Part I of this Appendix, in paragraph C of Part I of this Appendix, based on the ratio (R) of the group's population to the number of dentists serving it, together with the presence or absence of unusually high needs for dental service.

2. In comparing any two population groups within a designated shortage grouping, or in comparing a designated population group with a designated area within the same grouping, the area or population group with the larger population will be assumed to have the greater shortage. (In the case of Indian tribes, the population figure used will be that population served by each IHS facility which requires staffing.)

PART III—FACILITIES

A. Federal and State Correctional Institutions

1. Criteria. Medium to maximum security Federal and State correctional institutions will be designated as having a shortage of dental manpower if both of the following criteria are met:

(a) The institution has at least 250 inmates.

(b) The ratio of the number of inmates per year to the number of PTE dentists serving the institution is at least 1,500:1. (The number of inmates is the number of inmates present at the beginning of the year plus the number of new inmates entering the institution during the year, including those on short sentences who left before the end of the year.)

2. Determination of Degree of Shortage. The degree of shortage of a given correctional institution, designated as having a shortage of dental manpower, will be determined as follows:

(a) Grouping of Correctional Institutions. Correctional institutions will first be grouped as follows, based on number of inmates and/or the ratio (R) of inmates to dentists: Group 1—Institutions with 500 or more inmates and no dentists; Group 2—Institutions with 500-499 inmates and no dentists; or with any number of inmates and R < 5,000; Group 3—Institutions with 5,000 < R < 1,000.

(b) Relative Shortage within a Group. In comparing any two institutions within a

given group, the institution with the larger number of inmates will be assumed to have the greater shortage.

B. Public or Non-profit Private Facilities

1. Criteria. Public or nonprofit private facilities providing general dental services will be designated as having a shortage of dental manpower if both of the following criteria are met: (a) The facility is providing general dental services to an area or population group designated as having a dental manpower shortage; and (b) The facility has insufficient capacity to meet the dental care needs of that area or population group.

2. Methodology. In determining whether public or nonprofit private facilities meet the criteria established by paragraph B.1 of this Part, the following methodology will be used:

(a) Provision of Services to a Designated Area or Population Group

A facility will be considered to be providing services to a designated area or population group if either: (a) A majority of the facility's dental care services are being provided to residents of designated dental manpower shortage areas or to population groups designated as having a shortage of dental manpower; or

(b) The population within a designated dental shortage area or population group has reasonable access to dental services provided at the facility. Such reasonable access will be assumed if the population lies within 40 minutes travel time of the facility and no physical barriers (relating to demographic and socioeconomic characteristics of the population) do not prevent the population from receiving care at the facility. Indian Health Service facilities and migrant health centers (as defined in section 319 (a)(1) of the Act) are assumed to be meeting this requirement.

(b) Insufficient Capacity to Meet Dental Care Needs

A facility will be considered to have insufficient capacity to meet the dental care needs of a designated area or population group if either of the following conditions exists at the facility: (1) There are more than 5,000 outpatient visits per year per dentist on the staff of the facility than 4 weeks for routine dental services. Indian Health Service facilities will be considered to have insufficient capacity if the staffing requirements established by the Indian Health Service are not met.

3. Determination of Degree of Shortage

The degree of shortage of a facility designated as having a shortage of dental manpower will be determined as follows: (a) Facilities will be grouped as in paragraph C.1 of Part I of this Appendix, in the same groupings as the designated area or population group which they serve. (b) In comparing a facility with other designated facilities, areas, or population groups within the same grouping, the population figure used for the facility shall equal that proportion of the population of the designated area or population group which the facility serves. The area, population group, or facility with the larger population or service population will then be assumed to have the greater shortage.

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APPENDIX C—CRITERIA FOR DETERMINATION OF AREAS REQUIRING SERVICES OF PSYCHIATRIC MANPOWER

PART I—GENERAL PRINCIPLES

A. Criteria

A geographic area will be designated as having a shortage of psychiatric manpower if the following three criteria are met:

1. The area is a rational area for the delivery of psychiatric services.

2. One of the following conditions prevails within the area:

(a) The area has a population-to-psychiatrist ratio of at least 30,000:1;

(b) The area has a population-to-psychiatrist ratio of less than 30,000:1 but greater than 10,000:1 and has unusually high needs for mental health services;

3. Psychiatric manpower in contiguous areas are overutilized, seriously distant or inaccessible to residents of the area under consideration.

B. Methodology

In determining whether an area meets the criteria established by paragraph A of this part, the following methodology will be used:

1. **Rational Areas for the Delivery of Psychiatric Services.** (a) The following areas will be considered rational areas for the delivery of psychiatric services:

(i) An established mental health catchment area, as designated by the State Health Planning and Development Agency in consultation with the State's mental health authority, under the general criteria set forth in section 522 of the Community Mental Health Centers Act.

(ii) A portion of an established mental health catchment area whose population, because of topography, market or transportation patterns, distinctive population characteristics, or other factors, has limited access to psychiatric resources in the rest of the catchment area, as measured generally by a travel time of greater than 60 minutes to such resources.

(iii) A county or metropolitan area which contains more than one mental health catchment area, where data are unavailable by individual catchment area.

(b) The following distances will be used to estimate distances corresponding to 60 minutes travel time:

(i) Under normal conditions with primary roads available: 30 miles.

(ii) In mountainous terrain or in areas with only secondary roads available: 35 miles.

(iii) In flat terrain or in areas connected by interstate highways: 35 miles.

Within inner portions of metropolitan areas, the large variations in the scope of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In those areas, information on the public transportation system will be used to determine the distance corresponding to 60 minutes travel time.

2. **Population Count.** The population count used will be the total permanent resident population of the area, excluding inmates of institutions.

3. **Counting of Psychiatrists.** (a) All non-federal psychiatrists providing patient care (direct or other, including consultation and supervision), in ambulatory or other short-term care settings in residents of the area more than one-half day per week will be counted. These psychiatrists engaged solely in administration, research, and teaching

will be excluded. Adjustments for the following factors will be made:

(i) Psychiatric residents will be counted as 3 FTE psychiatrists to reflect the fact that a large portion of their time is training.

(ii) Foreign medical graduates (i.e., graduates of medical programs outside the U.S.) in psychiatry who do not have a stable immigration status (i.e., U.S. citizenship or a permanent visa), will be excluded from psychiatrist counts since their future availability to help provide psychiatric care to the area's population is uncertain.

(iii) Foreign medical graduates in psychiatry who have a stable immigration status but are not fully licensed to practice medicine will be counted as 3 FTE psychiatrists to reflect their practice limitations and time spent in training.

(iv) Psychiatrists who are semi-retired, who operate a reduced practice due to infirmity or other limiting conditions, or who are available in the population of an area only on a part-time basis will be discounted through the use of full-time equivalency figures. A 40-hour work week will be used as the standard for determining full-time equivalents in such cases. For practitioners working less than a 40-hour week every 4 hours (or 1/4 day), spent providing patient care services should be counted as 0.1 FTE, and each psychiatrist providing patient care 40 or more hours a week should be counted as 1.0 FTE psychiatrist.

(v) In some cases, psychiatrists located within an area may not be accessible to the general population of the area under consideration. Allowances for psychiatrists working in restricted facilities will be made on a case-by-case basis. Examples of such restricted practices include staff positions in correctional institutions, youth detention facilities, residential treatment centers for emotionally disturbed or mentally retarded children, and inpatient units of State or county mental hospitals.

(vi) In cases where there are mental health facilities or institutions providing both inpatient and outpatient services, those psychiatrists assigned to outpatient or other short-term care units will be counted. If the psychiatric staff is not specifically allocated to one service or the other, the number of psychiatrists in short-term care will be estimated on the basis of the relative workload in each type of setting.

(vii) Other physicians and other types of manpower (such as clinical psychologists, social workers, psychiatric nurses, alcoholism and drug abuse counselors, and other mental health workers), also make important contributions to the supply of alcohol, drug abuse, and mental health services and may reduce the need for psychiatrists. National equivalency values for their contributions are not included here, however, because of variations in their responsibilities across States and because of data inadequacies. Their contributions to the supply of psychiatric services will be taken into account when appropriate data and equivalency values become available.

4. **Determination of Unusually High Needs for Psychiatric Services.** An area will be determined to have an unusually high need for psychiatric services if two or more of the following criteria are met:

(a) 20 percent of the population (or of all households), have incomes below the poverty level, or the area has been designated as a poverty area in accordance with section 943 of the Community Mental Health Centers Act.

(b) A youth dependency ratio (ratio of children under 18 to population 18-64), in excess of 60 percent.

(c) An unemployment ratio (ratio of persons aged 16 and over to population 18-64), in excess of 30 percent.

(d) A high prevalence of alcoholism in the population, as indicated by a relative prevalence of alcoholism problems which exceeds that in 75 percent of all catchment areas (or other composite set of areas for which the prevalence index is computed), using the Index of Relative Alcoholism Prevalence developed by the National Institute on Alcohol Abuse and Alcoholism for the purpose of allocating funds under 15 U.S.C. 4871.

(e) A high prevalence of drug abuse in the population, as indicated by a relative prevalence of drug abuse which exceeds that in 75 percent of all metropolitan areas for which appropriate data are available, using the Heroin Problem Index developed by the National Institute on Drug Abuse.

5. **Contiguous Area Considerations.** Psychiatric manpower in areas contiguous to an area being considered for designation will be considered excessively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in each contiguous area:

(a) Mental health manpower in the contiguous area are more than 60 minutes travel time from the center of the area being considered for designation (measured in accordance with paragraph B (ii) of this part).

(b) Contiguous area population-to-psychiatrist ratios are in excess of 30,000:1, indicating that mental health manpower in contiguous areas cannot be expected to help alleviate the shortage situation in the area for which designation is being considered.

(c) Psychiatric manpower in contiguous areas are inaccessible to the population of the requested area because of geographic, cultural, language, or other barriers, or because of residency restrictions of programs or facilities providing such manpower.

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area, designated as having a shortage of psychiatric manpower, will be determined using the following procedure:

1. **Grouping of Areas.** Designated areas will first be assigned to groups, based on the ratio (R) of population to number of FTE psychiatrists and the presence or absence of unusually high needs for mental health services, according to the following table:

	High needs not indicated	High needs indicated
Group 1	No psychiatrist	No psychiatric
Group 2	R > 60,000	R > 60,000
Group 3	30,000 > R > 60,000	30,000 > R > 60,000
Group 4	10,000 > R > 30,000	10,000 > R > 30,000

All group 1 areas will be assumed to have a greater shortage than all group 3 areas, all group 2 areas will be assumed to have a greater shortage than all group 3 areas, etc. 2. **Relative Shortage within a Group.** In comparing any two areas within a group as defined above, the area with the larger population will be assumed to have the greater shortage.

PART II—POPULATION GROUPS

A. Criteria

Population groups within particular catchment areas will be designated as

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having a psychiatric manpower shortage if the following conditions prevail:

- (a) Access barriers prevent the population group from using these mental health resources which are present in the area; and
- (b) The ratio (R) of the number of persons in the population group to the number of PTE psychiatrists serving the population group, and practicing within 40 minutes travel time of the center of the area where the population group resides, is at least 30,000:1 (30,000:1) where unusually high needs for psychiatric services are indicated:

B. Determination of Degree of Shortage

The degree of shortage of a given population group, designated as having a shortage of psychiatric manpower, will be determined as follows:

1. The population group will first be assigned to groupings as in paragraph C.1 of Part I of this Appendix, based on the ratio (R) of the group's population to the number of PTE psychiatrists serving it, together with the presence or absence of unusually high needs for psychiatric services among the population group.
2. In comparing any two population groups within a degree-of-shortage grouping, or in comparing a designated population group with a designated area within the same grouping, the area or population group with the larger population will be assumed to have the greater shortage.

PART III—FACILITIES

A. Federal and State Correctional Institutions and Youth Detention Facilities

1. **Criteria.** Medium to maximum security Federal and State correctional institutions for adults or youth, and youth detention facilities, will be designated as having a shortage of psychiatric manpower if both of the following criteria are met:

- (a) The institution has at least 300 inmates; and
- (b) The ratio of the number of inmates per year to the number of PTE psychiatrists serving the institution is at least 2,000:1. (The number of inmates is the number of inmates or residents present at the beginning of the year, plus the number of new inmates or residents entering the institution during the year, including those who left before the end of the year.)

2. **Determination of Degree of Shortage.** The degree of shortage of a given correctional institution or youth detention facility, designated as having a shortage of psychiatric manpower, will be determined as follows:

- (a) **Grouping of Facilities.** Correctional facilities and youth detention facilities will first be assigned to groups, based on the number of inmates and/or the ratio (R) of inmates to PTE psychiatrists, as follows:
Group 1—Facilities with 500 or more inmates or residents and no psychiatrist.

Group 2—Other facilities with no psychiatrist, and facilities with 500 or more inmates or residents and R > 2,000.

Group 3—All other facilities.

- (b) **Determination of Degree of Shortage.** In comparing any two facilities within a group as defined above, the facility with the larger number of inmates or residents will be assumed to have the greater shortage.

B. State and County Mental Hospitals

1. **Criteria.** A State or county hospital will be designated as having a shortage of psychiatric manpower if both of the following criteria are met:

- (a) The mental hospital has an average daily inpatient census of at least 100 and
- (b) The number of workload units per PTE psychiatrist available at the hospital exceeds 600, where workload units are calculated using the following formula:

Total workload units—average daily inpatient census $\times$ 3 $\div$ (number of inpatient admissions per year) $\div$ 0.5 $\div$ (number of admissions to day care and outpatient services per year).

2. **Determination of Degree of Shortage.** The degree of shortage of a given State or county mental hospital, designated as having a shortage of psychiatric manpower, will be determined as follows:

- (a) **Grouping of Facilities.** State or county mental hospitals will first be assigned to groups based on the ratio (R) of workload units to number of PTE psychiatrists, as follows:
Group 1—No psychiatrist, or R < 1,000.
Group 2—1,000 < R < 1,500.
Group 3—1,500 < R < 2,000.

(b) **Relative Shortage Within a Group.** In comparing any two facilities within a group as defined above, the facility with the larger number of workload units will be assumed to have the greater shortage.

C. Community Mental Health Centers and Other Public or Nonprofit Private Facilities

1. **Criteria.** A community mental health center (CMHC), authorized by Pub. L. 94-63, or other public or nonprofit private facility providing alcohol, drug abuse, or mental health services to an area or population group, will be designated as having a shortage of psychiatric manpower if the facility is providing or is responsible for providing psychiatric services to an area or population group designated as having a psychiatric manpower shortage.

2. **Methodology.** In determining whether CMHCs or other public or nonprofit private facilities meet the criteria established in paragraph C.1 of this Part, the following methodology will be used:
(a) **Provision of Services to a Designated Area or Population Group.** The facility will be considered to be providing services to a designated area or population group if either:
(i) A majority of the facility's psychiatric services are being provided to residents of designated psychiatric manpower shortage areas or to population groups designated as having a shortage of psychiatric manpower.

(ii) The population within a designated psychiatric shortage area or population group has reasonable access to psychiatric services provided at the facility. Such reasonable access will be assumed if the population lies within 40 minutes travel time of the facility and nonphysical barriers (relating to demographic and socio-economic characteristics of the population) do not prevent the population from receiving care at the facility.

(b) **Responsibility for Provision of Services.** This condition will be considered to be met if the facility, by Federal or State statute, administrative action or contractual agreement, has been given responsibility for providing and coordinating a wide range of alcohol, drug abuse and/or mental health services for the area or population group, consistent with applicable State plans.

3. **Determination of Degree of Shortage.** The degree of shortage of a CMHC or other public or nonprofit private facility designat-

ed as having a shortage of psychiatric manpower shall be determined using the following procedure:

- (a) Facilities will be grouped as in paragraph C.1 of Part I of this Appendix, in the same groupings as the designated area or population group which they serve.

(b) In comparing a facility with other designated facilities, area, or population groups within the same grouping, the population figure used for the facility shall equal that proportion of the population of the designated area or population group which the facility serves. The area's population group, or facility with the larger population or service population will then be assumed to have the greater shortage.

APPENDIX D—CRITERIA FOR DETERMINATION OF AREAS HAVING SHORTAGES OF VISION CARE MANPOWER

PART I—GEOGRAPHIC AREAS

A. Criteria

A geographic area will be designated as having a shortage of vision care manpower if the following three criteria are met: 1. It is a rational area for the delivery of vision care services. 2. The estimated number of optometric visits supplied by vision care manpower in the area is less than the estimated requirements of the area's population for such visits, and the amount of this difference, that is, the computed optometric visit shortage, is at least 1,500 visits. 3. Optometric manpower in contiguous areas are excessively distant, overutilized, or inaccessible to the population of the area under consideration.

B. Methodology

In determining whether an area meets the criteria established by Paragraph A of this Part, the following methodology will be used:

1. **Rational Areas for the Delivery of Vision Care Services.** (a) The following areas will be considered rational areas for the delivery of vision care services: (i) A county, or a group of contiguous counties whose population centers are within 40 minutes travel time of each other; (ii) A portion of a county (or an area made up of portions of more than one county) whose population, because of topography, market or transportation patterns, or other factors, has limited access to contiguous area resources, as measured generally by a travel time of greater than 40 minutes to such resources.

(b) The following distances will be used to estimate distances corresponding to 40 minutes travel time: (i) Under normal conditions with primary roads available: 30 miles. (ii) In mountainous terrain or in areas with only secondary roads available: 20 miles. (iii) In flat areas or in areas connected by interstate highways: 35 miles. Within inner portions of metropolitan areas, the large variations in the scope of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In these areas, consideration on the public transportation system will be used to determine the distance corresponding to 40 minutes travel time.

3. **Determination of Estimated Requirement for Optometric Visits.** The number of optometric visits required by an area's population will be estimated by multiplying each of the following visit rates by the size of the population within that particular area group and then adding the 6 figures obtained to gether:

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ANNUAL NUMBER OF OPTHALMOLOGIC VISITS REQUIRED FOR DESIGNATION BY AREA

Age	Under 15	15-24	25-34	35-44	45-54	55-64	65 and over
Number of visits	0.11	0.20	0.30	0.35	0.38	0.41	0.45

(c) **Determination of Estimated Supply of Ophthalmic Visits.** The estimated supply of ophthalmic services will be determined by use of the following formula: Ophthalmic visits supplied = $5,000 \times (\text{ophthalmologists under 65}) + 3,500 \times (\text{ophthalmologists 65 and over}) + 1,000 \times (\text{ophthalmologists})$.

(d) **Determination of Size of Shortage.** Size of shortage (in number of ophthalmic visits) will be computed as follows: Ophthalmic visit shortage = visits required - visits supplied.

(e) **Contiguous Area Considerations.** Vision care manpower in areas contiguous to an area being considered for designation will be considered conservatively distant, overutilized or inaccessible to the population of the area if one of the following conditions prevails in such contiguous area: (a) Visits more than 60 minutes travel time from the center of the area being considered for designation (measured in accordance with paragraph 2.1(b) of this Part); (b) The estimated requirement for vision care services in the contiguous area exceeds the estimated supply of such services (based on the requirements and supply calculations previously described); (c) Manpower in contiguous areas are inaccessible to the population of the area because of specified access barriers (such as economic or cultural barriers).

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area or population group, designated as having a shortage of ophthalmic manpower, will be determined using the following procedure:

1. **Grouping of Areas and Population Groups.** Designated areas (and population groups) will first be assigned to groups, based on the proportion of the requirement for ophthalmic visits which is being supplied in the area or group, as follows: Group 1—Areas or groups with no ophthalmic visits being supplied (i.e., with no ophthalmologists or ophthalmologists). Group 2—Areas or groups where the ratio of ophthalmic visits supplied to ophthalmic visits required is less than 0.5. Group 3—Areas or groups where the ratio of ophthalmic visits supplied to ophthalmic visits required is between 0.5 and 1.0. All group 1 areas (and population groups) will be assumed to have a greater shortage than all group 2 areas, and all group 2 areas will be assumed to have a greater shortage than all group 3 areas.

2. **Relative Shortage within a Group.** In comparing any two areas within each group as defined above, the area with the larger computed shortage of ophthalmic visits will be assumed to have the greater shortage.

PART II—POPULATION GROUPS

A. Criteria

Population groups within particular geographic areas will be designated if the following criteria are met: (a) Members of the population group do not have access to the ophthalmic resources within the area (or in contiguous areas) because of unspecified

access barriers (such as economic or cultural barriers); (b) The estimated supply of ophthalmic services available to the members of the population group (as determined under paragraph 2.3 of Part I of this Appendix) is less than the estimated number of visits required by that group (as determined under paragraph 2.3 of Part I of this Appendix); and (c) The amount of the difference, that is, the estimated shortage, is at least 1,000 visits.

B. Determination of Degree of Shortage

The degree of shortage of a given population group will be determined in the same way as described for areas in paragraph C of Part I of this Appendix.

APPENDIX B—CRITERIA FOR DESIGNATION OF ACCESS BARRIERS OF OPHTHALMIC MANPOWER

PART I—GENERAL PRINCIPLES

A. Criteria

A geographic area will be designated as having a shortage of ophthalmic manpower if the following three criteria are met: 1. The area is a rational area for the delivery of ophthalmic services. 2. The area's ratio of population to foot care practitioners is at least 30,000:1, and the computed podiatric shortage is at least 0.5, that is, there is a need for at least one additional podiatrist. 3. Podiatric manpower in contiguous areas are overutilized, conservatively distant, or inaccessible to the population of the area under consideration.

B. Methodology

In determining whether an area meets the criteria contained in paragraph A of this Part, the following methodology will be used:

1. **Rational Area for the Delivery of Podiatric Services.** (a) The following areas will be considered rational areas for the delivery of podiatric services: (i) A county or a group of contiguous counties whose population centers are within 60 minutes travel time of each other; (ii) A portion of a county, or an area made up of portions of more than one county, whose population, because of geography, market or transportation patterns or other factors has limited access to contiguous area resources, as measured generally by a travel time of greater than 60 minutes from its population center to such resources.

(b) The following distances will be used to estimate distances corresponding to 60 minutes travel time: (i) Under normal conditions with primary roads available: 60 miles; (ii) In mountainous terrain or in areas with only secondary roads available: 30 miles; (iii) In flat areas or in areas connected by interstate highways: 35 miles. Within inner portions of metropolitan areas, the large variations in the scope of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In these areas information on the public transportation system will be used to determine the area corresponding to 60 minutes travel time.

2. **Population Count.** The population count used will be the total permanent resi-

dent civilian population of the area, based on the results of censuses, adjusted by the following formula to take into account the differing utilization rates of podiatric services by different age groups within the population:

Adjusted population = total population $\times$ (1 + 2.5% (percent of population 65 and over) - 0.44% (percent of population under 15)).

3. **Counting of Podiatric Practitioners.** (a) All podiatrists providing patient care will be counted. However, in order to take into account productivity differences in podiatric practice associated with the age of the podiatrist, the following formula will be utilized:

Number of FTE podiatrists = number of podiatrists $\times$ (1.0 - 0.01 (age 65 and over) + 0.01 (age 55 and over)).

(b) In order to take into account the fact that orthopedic surgeons and general and family practitioners devote a percentage of their time to foot care, the total available foot care practitioners will be computed as follows:

Number of foot care practitioners = number of FTE podiatrists $\times$ 0.15 (number of orthopedic surgeons) + 0.05 (number of general and family practitioners).

4. **Determination of Size of Shortage.** Size of shortage (in number of FTE podiatrists) will be computed as follows:

Podiatric shortage = adjusted population / 30,000 - number of foot care practitioners.

5. **Contiguous Area Considerations.** Podiatric manpower in areas contiguous to an area being considered for designation will be considered conservatively distant, overutilized or inaccessible to the population of the area under consideration if one of the following conditions prevails in such contiguous area:

(a) Podiatric manpower in the contiguous area is more than 60 minutes travel time from the center of the area being considered for designation; (b) Population-to-foot care practitioner ratios in contiguous areas are in excess of 30,000:1, indicating that contiguous area podiatric manpower cannot be expected to help alleviate the shortage situation in the area for which designation is requested; (c) Podiatric manpower in contiguous areas are inaccessible to the population of the area under consideration because of specified access barriers (such as economic or cultural barriers).

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area, designated as having a shortage of podiatric manpower, will be determined using the following procedure:

1. **Grouping of Areas.** Designated areas will first be assigned to groups, based on the ratio (R) of adjusted population to number of foot care practitioners, as follows: Group 1—Areas with no foot care practitioners or areas with R $\leq 60,000$ and no podiatrists. Group 2—Areas with R $\leq 60,000$ and podiatrists. Group 3—Areas with R $\leq 60,000$. All group 1 areas will be assumed to have greater shortage than all group 2 areas, and all group 2 areas will be assumed to have greater shortage than all group 3 areas.

2. **Relative Shortage within a Group.** In comparing any two areas within each group as defined above, the area with the larger adjusted population will be assumed to have the greater shortage.

APPENDIX P. CRITERIA FOR DESIGNATION OF AREAS HAVING SHORTAGES OF VETERINARY MANPOWER

PART I—GEOGRAPHIC AREAS

A. Criteria

A geographic area will be designated as having a shortage of pharmacy manpower if the following three criteria are met: 1. It is a rational area for the delivery of pharmacy services; 2. The number of pharmacists serving the area is less than the estimated requirement for pharmacists in the area; and 3. The computed pharmacist shortage is at least 5, that is, rounds off to a need for at least one additional pharmacist. 2. Pharmacies in contiguous areas are overutilized or conversely distant from the population of the area under consideration.

B. Methodology

In determining whether an area meets the criteria established by paragraph A of this Part, the following methodology will be used:

1. **Rational Areas for the Delivery of Pharmacy Services.** (a) The following areas will be considered rational areas for the delivery of pharmacy services: (i) A county, or a group of contiguous counties whose population centers are within 30 minutes travel time of each other; and (ii) A portion of a county, or an area made up of portions of more than one county, whose population, because of topography, market or transportation patterns or other factors, has limited access to contiguous area resources, as measured generally by a travel time of greater than 30 minutes to such resources.
- (b) The following distances will be used to estimate distances corresponding to 30 minutes travel time: (i) Under normal conditions with primary roads available: 30 miles. (ii) In mountainous terrain or in areas with only secondary roads available: 15 miles. (iii) In flat terrain or in areas connected by interstate highways: 30 miles. Within portions of metropolitan areas, the large variations in the access of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In these areas, information on the public transportation system will be used to determine the area corresponding to 30 minutes travel time.
2. **Counting of Pharmacists.** All active pharmacists within the area will be counted, except those engaged in teaching, administration, or pharmaceutical research.
3. **Determination of Estimated Requirement for Pharmacists.** (a) **Basic estimate.** The basic estimated requirement for pharmacists will be calculated as follows: Basic pharmacist requirements = $13 \times$ (resident civilian population/1000) = 0.013 (total number of physicians engaged in patient care in the area).
- (b) **Adjusted estimate.** For areas with less than 20,000 persons, an adjustment is made to the basic estimate to compensate for the lower expected productivity of small practices. Therefore:
 - (i) For areas with less than 30,000 persons: Estimated pharmacist requirement = $2 \times$ population/30,000 + basic pharmacist requirement.
 - (ii) For areas with 30,000 or more persons: Estimated pharmacist requirement = basic pharmacist requirement.
4. **Size of Shortage Computation.** The size of the shortage will be computed as follows: Pharmacist shortage = estimated pharmacist requirement - number of pharmacists available.

5. **Contiguous Area Considerations.** Pharmacies in areas contiguous to an area being considered for designation will be considered conversely distant or overutilized if either:

- (a) Pharmacy manpower in contiguous areas are more than 30 minutes travel time from the center of the area under consideration; or
- (b) The number of pharmacists in the contiguous area is less than or equal to the estimated requirement for pharmacists for the contiguous area (as computed above).

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area, designated as having a shortage of pharmacy manpower, will be determined using the following procedure:

1. **Grouping of Areas.** Designated areas will first be assigned to groups, based on the ratio of the number of pharmacists available to the estimated pharmacist requirement, as follows:
 - Group 1—Areas with no pharmacists.
 - Group 2—Areas where the ratio of available pharmacists to pharmacists required is less than 5.
 - Group 3—Areas where the ratio of available pharmacists to pharmacists required is between 5 and 1.5.
- All group 1 areas will be assumed to have a greater shortage than all group 3 areas, and all group 2 areas will be assumed to have a greater shortage than all group 3 areas.
2. **Relative Shortage within a Group.** In comparing any two areas within each group as defined above, the area with the larger computed shortage of pharmacists will be assumed to have the greater shortage.

APPENDIX Q—CRITERIA FOR THE DESIGNATION OF AREAS HAVING SHORTAGES OF VETERINARY MANPOWER

PART I—GEOGRAPHIC AREAS

A. Criteria for Food Animal Veterinary Services

A geographic area will be designated as having a shortage of food animal veterinary manpower if the following three criteria are met:

1. It is a rational area for the delivery of veterinary services.
2. The ratio of veterinary livestock units to food animal veterinarians in the area is at least 10,000:1, and the computed food animal veterinary shortage is more; this ratio is at least 5, that is, rounds off to a need for at least one food animal veterinarian.
3. Food animal veterinarians in contiguous areas are overutilized or conversely distant from the population of the area under consideration.

B. Criteria for Companion Animal Veterinary Services

A geographic area will be designated as having a shortage of companion animal veterinary manpower if the following three criteria are met:

1. It is a rational area for the delivery of veterinary services.
2. The ratio of resident civilian population to number of companion animal veterinarians in the area is at least 20,000:1, and the computed companion animal veterinary shortage is more; this ratio is at least 5, that is, rounds off to a need for at least one companion animal veterinarian.

3. **Companion animal veterinarians in contiguous areas are overutilized or conversely distant from the population of the area under consideration.**

C. Methodology for Determining Food Animal and Companion Animal Veterinary Manpower Shortages

In determining whether an area meets the criteria established by paragraphs A and B of this Part, the following methodology will be used:

1. **Rational Areas for the Delivery of Veterinary Services.** (a) The following areas will be considered rational areas for the delivery of veterinary services:
 - (i) A county, or a group of contiguous counties whose population centers are within 30 minutes travel time of each other.
 - (ii) A portion of a county (or an area made up of portions of more than one county) which, because of topography, market or transportation patterns or other factors, has limited access to contiguous area resources, as measured generally by a travel time of greater than 30 minutes to such resources.

(b) The following distances will be used to estimate distances corresponding to 30 minutes travel time: (i) Under normal conditions with primary roads available: 30 miles. (ii) In mountainous terrain or in areas with only secondary roads available: 15 miles. (iii) In flat terrain or in areas connected by interstate highways: 30 miles.

Within inner portions of metropolitan areas, the large variations in the scope of public transportation systems and traffic conditions do not permit standard mileage figures to be specified. In these areas, information on the public transportation system will be used to determine the distance corresponding to 30 minutes travel time.

2. **Determination of Number of Veterinary Livestock Units Requiring Care.** Since various types of food animals require varying amounts of veterinary care, each type of animal has been assigned a weight indicating the amount of veterinary care it requires relative to that required by the milk cow. These weights are used to compute the number of "Veterinary Livestock Units" (VLU), for which veterinary care is required.

The VLU is computed as follows: Veterinary Livestock Units (VLU) = (number of milk cows) + $3 \times$ (number of other cattle and calves) + $88 \times$ (number of hogs and pigs) + $88 \times$ (number of sheep) + $900 \times$ (number of poultry).

3. **Counting of Food Animal Veterinarians.** The number of food animal veterinarians is determined by weighting the number of veterinarians within each of several practice categories according to the average proportion of practice time in that category which is devoted to food animal veterinary care, as follows:

Number of Food Animal Veterinarians = (number of veterinarians in large animal practice, exclusively) + (number of veterinarians in bovine practice, exclusively) + (number of veterinarians in porcine practice, exclusively) + (number of veterinarians in poultry practice, exclusively).

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- 70 x (mixed practice veterinarians with greater than 50 percent of practice in large animal care)
- 5 x (mixed practice veterinarians with approximately 50 percent of practice in large animal care)
- 30 x (mixed practice veterinarians with less than 50 percent of practice in large animal care)

4. **Counting of Companion Animal Veterinarians** (that is, those who provide services for dogs, cats, horses, and any other animals maintained as companions to the owner rather than for food animals). The number of full-time equivalent companion animal veterinarians is determined by weighting the number of veterinarians within each of several practice categories by the average portion of their practice which is devoted to companion animal care by the practitioners within that category, as follows:

Number of Companion Animal Veterinarians =

- (number of veterinarians in small animal practice, exclusively)
- (number of veterinarians in equine practice, exclusively)
- 70 x (mixed practice veterinarians with greater than 50 percent of practice in small animal care)
- 5 x (mixed practice veterinarians with approximately 50 percent of practice in small animal care)
- 30 x (mixed practice veterinarians with less than 50 percent of practice in small animal care)

5. **Size of Shortage Computation.** The size of shortage will be computed as follows:

(a) Food animal veterinarian shortage = $(VLU/10,000) - (\text{number of food animal veterinarians})$.

(b) Companion animal veterinarian shortage = $(\text{resident civilian pop./50,000}) - (\text{number of companion animal veterinarians})$.

6. **Contiguous Area Considerations.** Veterinary manpower in areas contiguous to an area being considered for designation will be considered exclusively distant from the population of the area or overutilized if one of the following conditions prevails in each contiguous area:

(a) Veterinary manpower in the contiguous area are more than 60 minutes travel time from the center of the area being considered for designation (measured in accordance with paragraph C.1(b) of this part).

(b) In the case of food animal veterinary manpower, the VLU-to-food animal veterinarian ratio in the contiguous area is in excess of 10,000:1.

(c) In the case of companion animal veterinary manpower, the population-to-companion animal veterinarian ratio in the contiguous area is in excess of 10,000:1.

C. Determination of Degree of Shortage

The degree of shortage of a given geographic area, designated as having a short-

age of veterinary manpower, will be determined using the following procedure:

1. **Grouping of Areas.** Designated areas will first be grouped as follows: Group 1—Areas with a food animal veterinarian shortage and no veterinarians. Group 2—Areas (not included above), with a food animal veterinarian shortage and no food animal veterinarians. Group 3—All other food animal veterinarian shortage areas. Group 4—All companion animal shortage areas (not included above), having no veterinarian. Group 5—All other companion animal shortage areas.

All group 1 areas are assumed to have greater shortage than all group 2 areas, all group 2 areas are assumed to have a greater shortage than all group 3 areas, etc.

2. **Relative Shortage within a Group.** In comparing any two areas within group 1, or any two areas within group 2, the area with the larger number of VLU's will be assumed to have the greater shortage. In comparing any two areas within group 3, the area with the larger ratio of VLU's to food animal veterinarians will be assumed to have the greater shortage. In comparing any two areas within group 4, the area with the higher ratio of population to companion animal veterinarians will be assumed to have the greater shortage.

[FPR Doc. 78-344 Phase 1: 9-78; 9-88 am]

Errata Sheet for HEALTH MANPOWER SHORTAGE AREAS: Criteria for Designation

Page 1594, column 3: The formula for calculating the figure for Adjusted population should read:

Adjusted population = total population $\times (1 + 2.2 \times (\text{percent of population 65 and over}) - 0.44 \times (\text{percent of population under 17}))$

Page 1595, column 1: The formula for calculating the size of shortage should read:

Pharmacist shortage = estimated pharmacist requirement - number of pharmacists available

EDUCATIONAL COMMISSION for FOREIGN MEDICAL GRADUATES

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July 10, 1980

The Honorable Elizabeth Holtzman
Chairwoman, Subcommittee on Immigration,
Refugees, and International Law
Committee on the Judiciary
United States House of Representatives
Rayburn Office Building
Washington, D.C. 20515

Dear Chairwoman Holtzman:

This is in response to your request for me to reply to a series of seven questions relating to foreign medical graduates to supplement my testimony on behalf of the Educational Commission for Foreign Medical Graduates before the Subcommittee on Immigration, Refugees and International Law.

I appreciate this opportunity to respond to the questions which address issues that are relevant to certain provisions of H.R. 7118, a bill to amend the Immigration and Nationality Act with respect to the admission of certain aliens for participation in graduate medical education or training programs.

The questions, and my response to each, follow:

1. *How would you characterize the value of the exchange program to other nations?*

The Exchange Visitor program under which alien physicians may enter the United States to participate in graduate medical education or training programs in areas of special expertise not available in their home countries has obvious intrinsic educational values. Supplying physicians from Third World (or other) countries with special knowledge and skills that can be "taken home" and applied, for the benefit of the people of those countries, is a worthy objective.

The Honorable Elizabeth Holtzman
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In addition to their application of the knowledge and skills learned in the United States to the direct treatment of patients in other nations, many Exchange Visitors returning to their home countries will become members of medical school faculties and enrich medical education in those countries.

Beyond these, the concept of improving international understanding, enhancing the exchange of ideas, philosophies of government and way of life is an extremely important consideration when attempting to measure the value, or the beneficial effects of the exchange visitor program on other nations.

In a world in which there is wide misunderstanding of national goals and objectives, any program that will enhance the knowledge of people of other nations about the United States must be viewed as important. This is particularly true in the case of physicians who frequently become important opinion makers in many countries of the world.

At present, the indoctrination of alien physicians in understanding the good points of democracy and United States domestic and foreign policies is more passive than it is active. I am not proposing that active indoctrination be required, as it is in Marxist countries. Nonetheless, the experience in living in the United States, for four to six years of graduate medical education, does provide a foundation for better understanding of the United States in later years in the home country.

2. *Who determines which medical services are "exportable", the home-country of the foreign medical graduate, the U.S. Government?*

I am uncertain about the meaning of "exportable medical services" in this context since medical services, as such, are not ordinarily viewed as "exportable products". However, medical school graduates ("products of medical education") can be considered exportable (and exported) under certain circumstances. Some countries of the world have been seen as "producing" physicians in excess of those countries' needs and utilizing the "products" for exportation, primarily to the United States.

Since physicians in this country ordinarily achieve income levels that are above the average, those that have been "imported" by the United States frequently send United States funds back to their home countries. Occasionally, this has produced a significant improvement in the "balance of payments" in favor of the foreign "donors" or "exporters" of physicians. Six or seven years ago, a Secretary of the former Department of Health, Education, and Welfare supported the concept of "importing" physicians, rather than educating them in the United States. From his point of view, the educational process could be accomplished abroad in a more cost-effective manner, reducing the need for the then ever-increasing requests for commitment of tax funds to support medical education. Obviously, this addressed only financial support and ignored the quality of the medical education.

The Honorable Elizabeth Holtzman

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In the past, neither the "exporter" (the foreign country) nor the "importer" (the United States) determined the medical specialty of the "physician-product" to be imported or exported. Alien foreign medical graduates would enter the United States as "entrepreneurs", seeking the best option available for training. Frequently, they would change training objectives several times, while seeking training opportunities at the most prestigious hospitals in the United States.

3. *The preponderance of FMG's are from the Philippines, where do other countries send their medical graduates for further training?*

In recent years, ECFMG examinations have been administered to students and graduates of more than 700 medical schools that are located in 95 to 100 countries of the world. And, although it may have seemed as if the preponderance of FMG's have been from the Philippines, the following table shows the results of ECFMG examinations for the past five years:

Total Passing <u>Medical Science</u> Part of ECFMG Examinations			
	<u>Worldwide</u>	<u>Schools in the Philippines</u>	<u>Percent from Philippine Medical Schools</u>
1975	13,628	592	4.34%
1976	13,718	489	3.56%
1977	8,602	311	3.61%
1978	5,726	272	4.75%
1979	6,772	400	5.91%

So applicants pass ECFMG examinations while they are medical students. Others may not pass until they have completed their medical education (or for several years later). The totals shown contain applicants from both categories and thus represent the maximum number newly available to apply to enter the United States in any one year. With immigrant visa numbers unavailable in all categories for Filipinos except first and second preference, obviously there is a large backlog of Philippine national graduates of Philippine medical schools waiting for visa numbers. This could make the "preponderance" of Filipinos seem all the greater.

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ECFMG is the sponsor of an exchange visitor program for alien graduates of foreign medical schools. Physicians from more than 35 countries are represented among the 853 applications most recently received for initial or continuing sponsorship for the 1980-1981 training year. Seventeen percent (146) are from the Philippines. The home countries of the other 83 percent range from the British Isles and Europe to North, Central and South Africa; from the Near East and the Mid East to Southeast Asia; from Japan to Australia; from Canada to Central and South America.

A number of physicians from former British Commonwealth countries continue to go to the United Kingdom for their graduate medical education. Some from other countries yet seek their graduate training in Europe. However, opportunities are limited.

Unfortunately, each year everlarger numbers of graduates of medical schools from countries where Marxist ideas have gained popularity are being recruited by the Soviet Union to go (with all expenses paid!) to the USSR or countries on the fringe of the Iron Curtain for graduate medical education or training "opportunities." We have heard that several hundred young physicians from Panama and Nicaragua have been taken to the Soviet Union within the past year. This is unfortunate, since these Central American neighbors will be indoctrinated in Communism and receive very limited graduate medical education. I have been told by physicians from Egypt and the People's Republic of China that the "products" of residency programs in the USSR return to their home countries with very little additional medical knowledge, and virtually no "hands-on" experience of the type that is characteristic of graduate medical education in the United States.

Although some Saudi Arabians continue in training programs in the United States, I have learned in conversations with the deans of the King Faisal Medical School and of the medical school in Riyadh that they are moving Saudi Arabian graduate trainees from the United States to Canada, where they can remain long enough to complete a full training program in a specialty.

Graduate medical education in the United States is the best in the world. And it is the dream of most young physicians from throughout the world to come to this country, obtain certification in a specialty and return to their homelands to practice.

4. *When the ECFMG notifies the Liaison Committee on Graduate Medical Education of program and institution waivers, what is the response of the LCGME? Do they evaluate those programs?*

In 1978 and, again, in August 1979, I notified the Liaison Committee on Graduate Medical Education (LCGME) of the various graduate medical education programs that had qualified for substantial disruption waivers during the year.

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I expect that the information is made available for the residency review committees to consider when they evaluate training programs for approval of the adequacy of the educational experience available to trainees in those programs. Alien physicians under ECFMG sponsorship as exchange visitors can be sponsored only in programs that are approved by the appropriate residency review committee for their educational value and then accredited by the LCGME. Therefore, I see no reason for the LCGME to immediately re-evaluate programs just because they have qualified for substantial disruption waivers.

5. *How does the FLEX exam compare to the VQE, to the NBME?*

The National Board of Medical Examiners (NBME) examination consists of three parts; NBME Part I, Part II and Part III. The NBME Part I examination contains approximately 1000 items (questions) from seven basic medical sciences (anatomy, biochemistry, microbiology, behavioral science, physiology, pathology and pharmacology). The Part II examination contains approximately 1,000 items from six clinical sciences (internal medicine surgery, pediatrics, obstetrics and gynecology, preventive medicine and public health, etc.). The NBME Part III examination is a sophisticated instrument that utilizes a great deal of pictorial material such as photographs of X-rays, electrocardiograms, color photographs of a variety of lesions and requires the examinee not only to identify the abnormality (or normal feature) but, also to utilize the information to solve a clinical situation in carrying out a course of appropriate therapy. In addition, Part III contains a number of programmed testing problems.

Part I, which requires two full days, is usually taken by medical students at United States medical schools near or at the end of the second year of medical schools. Part II, which also requires two full days, is taken near the end of the fourth year of medical school. Part III is taken following eight or nine months of clinical experience in what was formerly known as the internship, now known as the first year of graduate medical education. Successful completion of all three parts is required for National Board Certification.

The Federation Licensing Examination (FLEX) is also a three part examination; FLEX Day I, Day II and Day III. FLEX consists of material from NBME Part I, Part II and Part III examinations. The NBME Part I items contained in FLEX Day I are selected by members of the Federation of State Medical Boards for the clinical applicability of the questions. In the scoring process, FLEX is weighted, so that only one-sixth of the "FLEX Weighted Average" score is derived from the basic sciences. The FLEX Day II (clinical sciences) material is derived from National Board Part II questions, but is weighted at two-sixths (one-third) in the final computation of scores. Day III of FLEX is a full National Board Part III examination and is weighted to provide one-half (three-sixths) of the FLEX score.

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The Visa Qualifying Examination is a two day examination; VQE Day I and Day II. It is administered on two successive days and can only be taken by applicants who have completed the full medical curriculum. Day I consists of basic science material, approximately one half of a National Board Part I examination. Day II contains clinical science material, approximately one-half of a National Board Part II examination. In order for VQE to be considered equivalent to NBME Parts I and II for the purposes of the PL 94-484 examination requirement, Day I is scored at the level of performance required of second year students in United States medical schools. Approximately eleven percent of American medical students fail the NBME Part I examination the first time that they take it, even though they have just concluded two years of intensive study of the basic sciences. Medical educators believe that this level of performance is required to make certain that medical students understand the basic medical sciences sufficiently to provide a solid foundation for the third and fourth year medical school emphasis on the clinical sciences.

VQE examinees are required by PL 94-484 to be graduates of medical schools and, in most cases, have moved well beyond medical school in their professional careers by the time that they take VQE. In most cases, they are working in clinical areas and are not involved in the intensive study of the basic sciences as their American counterparts are when they take the NBME Part I examination.

In comparison the FLEX approach (weighted average) is far more realistic than VQE for medical school graduates who spend the greater part of their time in some form of medical practice, solving clinical problems in a practical manner and utilize basic science material principally as it is applicable to clinical medicine.

6. *What has been the pass rate for foreign medical graduates taking the Visa Qualifying Exam over the last two years?*

The results of the 1977, 1978 and 1979 Visa Qualifying Examinations are shown on the attached table. Day I consists entirely of National Board Part I, basic science questions, and Day II of National Board Part II, clinical science questions. Otherwise, the table should require no additional explanation.

Visa Qualifying Examination Results

Year	Total Taking	Pass Day 1 Pass Day 2	Pass Day 1 Fail Day 2	Fail Day 1 Pass Day 2	Fail Day 1 Fail Day 2	Visa Qualified* ECFMG Certified
1977	4,611	1,163 (25%)	0 (0%)	1,943 (42%)	1,505 (33%)	710 (15%)
1978	3,217	945 (29%)	10 (0.3%)	1,692 (53%)	570 (18%)	668 (21%)
1979	4,790	1,437 (30%)	13 (0.2%)	2,137 (45%)	1,203 (25%)	967 (20%)

* Represents number of applicants who at the time of result letters met the requirements for ECFMG certification and the examination requirements to obtain a visa.

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7. To what do you attribute the declining number of exchange visitors entering the U.S.? 1) Failure to pass the VQE; or 2) The limitation on the duration of an alien's stay in a program?

The Visa Qualifying Examination (VQE), as I have indicated above is difficult for alien physicians, and it has sharply reduced the number who can qualify to enter the United States as Exchange Visitors. However, physicians generally react to a challenge. And the number of applicants for VQE is increasing. I believe that within a few years the pool of passers will increase sufficiently to provide an adequate number of Exchange Visitors to occupy the positions available for them. So, although the VQE is a tough examination, alien physicians are reacting to the challenge and increasing numbers will pass it to obtain experience as participants in graduate medical education training programs in the United States.

On the other hand, the limitation on the duration of stay has discouraged many alien physicians and has caused the medical education communities in a number of countries to look elsewhere for graduate training for their fledgling physicians. I have noted earlier the Saudi Arabian medical educators who will continue to send their young physicians to Britain or to Canada as long as the limited duration of stay for exchange visitors is in effect in the United States. Also, many physicians who might have come to the United States for their graduate education, are going to the USSR, or to countries on the fringe of the Iron Curtain for their training. Since physicians are looked upon in many of the Latin American countries as learned, and create opinion, they frequently are elected to influential positions in government. If they are trained in the United States, they will take home with them some of the good things about the United States and our system of democracy. It would be good to have them on our side!

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Please let me know if you wish to have additional information or have any questions about my response to the seven queries, or to any other issues related to the proposed PL 7118 amendments to the Immigration and Nationality Act.

Sincerely,

Ray J. Casterline, M.D./M.S.

Ray L. Casterline, M.D.
Executive Director

RLC:leh
Enclosure

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**International
Communication
Agency**

United States of America
Washington, D. C. 20541



June 24, 1980

The Honorable
Elizabeth Holtzman
Chairwoman, Committee on
the Judiciary
Subcommittee on
Immigration, Refugees,
and International Law
House of Representatives

Dear Liz:

We have cooperated with the Department of Health and Human Services and the Educational Commission for Foreign Medical Graduates in gathering information and responding to the questions posed in your letter to me of May 20th, received in this office on June 10th.

For ease of reference, we have numbered the questions and answered each on a separate page. Should your staff wish further information, my colleague, Joseph A. Blundon, Esq., will be happy to be of assistance. He can be reached on 724-9552.

Sincerely yours,

Michael A. Glass
General Counsel

Enclosure

QUESTION NO. 1

On what basis are the majority of waivers of the two-year foreign residence requirement granted?

USICA has no generally applicable answer to this question. USICA has no authority to grant waivers under Title 8, United States Code, Section 212(e) and Title 8, Code of Federal Regulations, Section 212.7(c), but may recommend for or against the granting of waivers. The Department of Justice (DOJ) (through its Immigration and Naturalization Service (INS)) makes the final decision on waivers in all cases. For example, a request from an exchange visitor foreign medical graduate for a waiver of the two-year foreign residence requirement on the ground of exceptional hardship to the exchange visitor's American citizen (or lawful permanent resident) spouse or child, is initially submitted to INS. If INS finds that there would not be exceptional hardship, it denies the request without referral to USICA. The applicant, after administrative review within INS, can have judicial review of the decision. If INS finds that there would be exceptional hardship, it refers the application to USICA for a review and recommendation from the point of view of exchange visitor program purposes and goals and the potential impact of a waiver on the foreign relations of the United States. If USICA recommends against a waiver, the request is not granted, and the courts have ruled that such decision is not judicially reviewable. If USICA recommends in favor of a waiver, the Attorney General (by delegation INS) must still consider and decide whether such waiver is in the public interest.

Prior to the enactment of Public Law 94-484, as amended, the majority of foreign medical graduates applied for and were granted waivers of the two-foreign residence requirement based on "No Objection" statements from their governments. The impact of Public Law 94-484, as amended, has resulted in a significant reduction in waivers for foreign doctors as "No Objection" statements are no longer available to those doctors who entered the U.S. on or after January 10, 1977 for graduate medical education and training. P.L. 94-484 requires that alien physicians make a commitment to return to their home country upon completion of training in the U.S. Waivers for foreign doctors now are approved only for those who qualify on the basis of exceptional hardship, persecution or a request from an interested U.S. Government Agency.

The Exchange Visitor Waiver Review Board of the Department of Health and Human Service advises us that it considers applications for the waiver of the two-year foreign residence requirement which are submitted by hospitals, institutions, and other organizations, on behalf of exchange visitors who are involved in research in health and related fields and when DHHS has been asked to act as the "interested Federal

QUESTION NO. 1 Cont.

agency" in requesting a waiver for an individual applicant. When necessary, it considers applications relating to welfare and social security. Each case is evaluated individually on the basis of the facts available. That Board has a stringent and restrictive policy with respect to requesting waivers for foreign visitors under the exchange visitor program. The general criteria which are applied are:

- (1) The program or activity of the applicant institution or organization in which the exchange visitor is employed must be of high priority and significance in an area of interest to the Department. The Waiver Review Board will not request a waiver when the documentation clearly demonstrates that the problem is primarily one of recruitment in order to overcome a local community or institutional manpower shortage, however serious.
- (2) The exchange visitor must be needed as an integral part of the program or activity, or of an essential component thereof. The Board will not request a waiver when the principal problem appears to be one of administrative or program inconvenience to the institution or other employer.
- (3) The exchange visitor must possess outstanding qualifications, training, and experience. The Board will not request a waiver simply because an individual has specialized training or experience or is occupying a senior staff position in a university, hospital, or other institution.

What proportion are disapproved and for what reasons?

For the months of January through mid-June, 1980 approximately one-half of all waiver application requests to DHHS Exchange Visitor Waiver Review Board were disapproved. These applications were disapproved because they failed to meet the strict criteria listed above.

All of the criteria must be fully met before the Board can request the International Communication Agency to recommend a waiver to the Attorney General for applicant within the Board's jurisdiction.

QUESTION NO. 2

In recent testimony before another Committee you stated that FMG's do return home to practice medicine. How do you know if the "J" visitors return and whether they use the skills acquired during their participation in the exchange program?

USICA has been advised from reports by U.S. physicians travelling abroad, by such groups as the AMA, the American College of Surgeons, the American College of Physicians, and the Educational Commission for Foreign Medical Graduates, and by members of the foreign diplomatic corps of certain governments that most exchange visitor foreign medical graduates have returned home and are utilizing their skills. Because most foreign physicians are not funded by a Federal source, the Agency's limited funds for research and evaluation has precluded it from doing an in-depth study of foreign physicians on their return home. Limited research and evaluation funds are earmarked primarily for those programs which are funded under the Mutual Educational and Cultural Exchange Act. While USICA would consider undertaking a comprehensive evaluation of privately sponsored programs, existing resources will not permit it.

QUESTION NO. 3

When substantial disruption waivers are granted do you ever make or solicit recommendations as to how those hospitals can better plan their reduced reliance on FMGs? Does the Substantial Disruption Waiver Review Board make recommendations? Should DHHS be required to respond to the plan?

Currently, the Board advises that technical assistance in the form of recommendations on FMG-reduction strategies is not provided by the Board.

The waiver provision mechanism (i.e., review of applications by the ECFMG and by the Federal-level Substantial Disruption Waiver Appeal Board) has been in operation for only two years, from May 1978 to date. The number of applications during the two years has been relatively small. Criteria for implementation of the program were developed after extensive analysis of the expected national and regional impact of the amendments of 1976. During the two years, it has been possible to make approval/disapproval decision at the Tier I level (ECFMG-review level which does not require departmental input) in sufficient numbers (70 program requests) to reduce the load at the Federal level to a manageable number (50 program requests). This has allowed the waiver provision to be implemented efficiently, equitably and as effectively as possible with the limited resources available.

The administration of the current waiver provision has included stringent requirements for detailed narratives on (1) the service-related problems associated with a potential reduction in FMGs; and (2) the plans for reducing dependence on FMGs. However, this requirement has been placed only on Tier II level applications.

Tier II level applications are from programs and institutions which (1) meet the eligibility criteria but are requesting waivers in excess of the numerical limitations or (2) do not meet the eligibility criteria and can demonstrate a need for waivers based on a substantial description of health services.

Favorable action by the Waiver Appeal Board is based on clear and convincing evidence that, without such waivers, a severe "substantial disruption" of health services would result. Applications must include a full and detailed discussion of the specific problems that programs and institutions anticipate without such waivers, what alternative provider resources and methods have been sought to meet the deficit in health services and what specific plan will be followed for phasing down, year-by-year, the reliance on alien physicians.

QUESTION NO. 4

Which countries have sent their medical graduates to the Soviet Union or Soviet-Bloc countries as a result of the three-year limitation on alien's participation in a program? In what programs were those aliens enrolled?

This Agency endeavored to obtain hard data on FMGs going to the Soviet Union or other countries as a result of the rigidifying of the requirements for foreign physicians desiring to come to the U.S. Enclosed is a copy of our circular airgram to our posts abroad dated May 14, 1979. Countries which expressed concern are listed below. Further data can be obtained from the American College of Surgeons (Dr. Joseph Evans).

Algeria	Morocco
Canada	Pakistan
Cyprus	Saudi Arabia
Honduras	Singapore
Ireland	Sudan
Israel	Sweden
Kenya	United Arab Republic
Mexico	Venezuela

INTERNATIONAL COMMUNICATION AGENCY

OUTGOING AIR POUCH
MESSAGEUNCLASSIFIED
Classification

SENT TO USICA CIRCULAR

Origin
ECA/IFB-10
Info

CM-332

May 14, 1979

GC

FROM: USICA

EU

E.O. 11652 W/A

NEA

Subject: Graduate Medical Education for Foreign Physicians

AR

Reference: Departmental A-1409 April 12, 1978

AF

EA

STATE

The Circular under reference enclosed a reprint from the Federal Register of March 31, 1978 which sets forth the regulations governing alien physicians coming to the United States under Exchange-Visitor Programs to pursue graduate medical education or training programs. These regulations were published as a result of the enactment of Public Law 94-484, as amended. This new law places very rigid requirements on foreign physicians who desire to come to this country for their graduate medical education and training.

The purpose of this communication is to obtain an overview of the impact which the new law has had abroad. Posts are requested to inform the Agency of the following:

1. What, if any, concern has been expressed by foreign governments or ministries of health regarding the adverse impact which the law has had on graduate medical educational training opportunities in the U.S. for foreign physicians? Several countries have written directly to the White House, the Agency and the Department of State expressing grave concern about the restrictions which the new law has had on training opportunities in this country for their medical personnel. Other countries have expressed their concern to the Educational Commission for Foreign Medical Graduates.

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PRINT IN THE "HAR ON WASTE" USE APPROACH INSTEAD OF TELEGRAMS

QUESTION NO. 5

Should there be timetables for reporting the developments of the "Comprehensive plan" for those institutions/programs which have received substantial disruption waivers? Bi-annually, every three months?

DHHS advises us that, as currently administered, reports on plans for decreasing reliance on foreign medical graduates are included by institutions/programs in the narrative statements submitted with their applications. If approved, applicants have access to utilization of a designated number of waivers in the year for which the request was made. Subsequent requests for relief require reapplication and reporting on the development and implementation of the previously stated plan. If no relief beyond the first request is needed, the institution/program is not required to make periodic reports to the Federal Government.

The current process places appropriate and substantial reporting burdens on institutions at the time of initiating request for relief. Institutions/programs which appear to be having difficulty in reducing reliance on FMGs as reflected in the need for additional yearly waivers, may need additional monitoring. However, it is probably unnecessarily burdensome to monitor applicants which use the system for a single, short-term requirement and do not intend to utilize the waiver mechanism extensively.

Semi-annual or annual reports should be sufficient for those institutions/programs which will require monitoring.

QUESTION NO. 6

How are educational institutions in other countries reacting to the more stringent U.S. visa requirements for FMG's?

U.S.I.C.A. has had no direct contact with educational institutions in foreign countries pertaining to their reactions to the stringent requirements of Public Law 94-484.

Question No. 7

As one of the representatives on the Substantial Disruption Waiver Appeal Board, do you feel the requests for waivers have been accompanied by proper documentation as to efforts made to reduce reliance on FMGs?

Yes. Some applicants have provided extensive narrative statements regarding the efforts made to reduce reliance on FMGs, while others have provided very limited and/or inadequate information. The latter applications have been returned to the institutions/programs with requests for the inclusion and/or elaboration of information needed to make a decision on their requests.

Question No. 8

How do you view the role of the U.S. in medical education training for the future?

The elimination of selective U.S. immigration policies that favored the immigration of physician manpower should not be accompanied by a cutback of international exchange programs. The United States should continue to foster mutually beneficial international health manpower training involving collaboration between the U.S. and foreign countries. However, the system established for exchange and training should be carefully managed in such a way that harmful "brain drain" may be avoided. Programs which have succeeded in avoiding this problem have been those which have involved physician manpower who were practicing in their home countries, who were selected to acquire additional skills needed in the home country and who were scheduled to return to positions back home. In addition to the direct benefits derived from skill development, indirect benefit result from improvements that occur in the home country health system when these physicians return home.

From the standpoint of our long range international relationships with other nations, United States involvement in medical education in the immediate future is essential. The U.S. has the best overall medical system in the world. Physicians from other countries have a strong desire to pursue their educational and training programs in this country. Certification by an American Medical Specialty Board for a foreign physician has far reaching levels in the home country where the physician is generally a key opinion leader in the community.

Question No. 9

What is the review process for substantial disruption waivers?

The review process for substantial disruption waivers is a two-tier activity. With regard to the first tier, programs or institutions which meet specified numerical criteria described for each category of application, may apply for, and receive waivers up to a phased limit which declines annually. The ECFMG has assumed responsibility for the administration of this first tier.

A second tier is available for programs and institutions which meet or may not meet the eligibility criteria and are requesting waivers in excess of the numerical limitations under Tier I or can demonstrate need for waivers based on substantial disruption of health services. Applications are considered by a Substantial Disruption Waiver Appeal Board, chaired by the Administrator, HRA, and composed of Federal representatives from those agencies with major interests in the impact of FMGs on the health care system: HRA, HCFA, INS, HSA, USICA, ADAMHA.

Favorable action by the Board on appeal applications is based on clear and convincing evidence that, without such waiver(s), a substantial disruption of health services (not disruption of educational or training program) would result.

After waiver applications have been approved, the hospitals submit Exchange-Visitor sponsorship application forms (IAP-66) to ECFMG which processes them under the authority of the U.S. International Communication Agency.

The attached table summarizes the number of waivers requested, approved and utilized for calendar years 1978 and 1979, under Tier I and Tier II.

Question No. 9

How are the numbers determined?

FMGs are not "blanketed in" under substantial disruption waivers. They are allowed to come in to the U.S. without having to comply with certain requirements (viz. the VQE), but thereafter must comply with all requirements of the law, including the VQE.

NUMBER OF WAIVERS REQUESTED, APPROVED AND UTILIZED
BY APPLICANTS FOR SUBSTANTIAL DISRUPTION
CALENDAR YEARS 1978 and 1979

TIER I

<u>Regions</u>	<u># of Applications*</u>	<u># of Waivers Requested</u>	<u>WAIVERS</u>	
			<u># of Waivers Approved</u>	<u># of Waivers Utilized</u>
Northeast	25	76	54	42
Central Northeast	17	21	13	10
South	3	3	2	2
Central Northwest	2	3	2	2
Southwest	03	03	1	1
West	1	2	0	—
	—	—	—	—
TOTALS	51	108	72	57

TIER II

<u>Regions</u>	<u># of Applications*</u>	<u># of Waivers Requested</u>	<u>WAIVERS</u>	
			<u># of Waivers Approved</u>	<u># of Utilized</u>
Northeast	15	61	52	26
Central Northeast	3	3	2	0
South	1	2	0	0
Central Northwest	0	0	0	0
Southwest	0	0	0	0
West	0	0	0	0
	—	—	—	—
TOTALS	19	66	54	26

QUESTION NO. 10

What recommendations has the Review Board made in those instances where waiver requests have continued to increase?

There have been three (3) cases where the applications for waiver appeal have reflected an increased reliance on FMGs over the base year, 1978. The Board recommended disapproval of two of the requests for waivers. The other application was approved for a lesser number of waivers than had been requested. The applicant was informed of the Waiver Appeal Board's concern that the intent of the law, (i.e., to reduce the reliance on FMGs) would be subverted by approval of the number of waivers requested. In this case, there would have been an increase of one position over the 1978 base year.

QUESTION NO. 11

What role has DHHS played on the Review Board?

The Substantial Disruption Waiver Appeal Board is chaired by the Administrator of the Health Resources Administration (HRA) in the Department of Health and Human Services (DHHS). The Executive Secretary's function of the Board is located within HRA. Five other Federal agencies are represented on the Board. They are as follows: Health Services Administration, DHHS; Health Care Financing Administration, DHHS; Alcohol, Drug Abuse, and Mental Health Administration, DHHS; Immigration and Naturalization Service and the International Communication Agency.

QUESTION NO. 11, Part II

At what point did the Review Board foresee the impending health care crisis in New York?

As early as June 1979, the Waiver Appeal Board was concerned that alternatives for meeting the future needs of the educational/service programs and plans for phasing down reliance on alien physicians had not been adequately addressed by the New York applicants. Thus, the Chairman of the Board met with the Executive Vice President, New York Health and Hospital Corporation on July 25, 1979, to discuss the problems seen by the Board in its review of applications from New York and the long term plans being developed to deal with staffing issues after 1980, when the waiver provision expires.

Further discussion of the physician manpower problems in graduate medical education created by the reduction in the number of FMGs available in New York City, was held on December 11, 1979, with a delegation from New York City and New Jersey.

**University of Pittsburgh**

SCHOOL OF MEDICINE
University Professor of Medicine

June 16, 1980

Congresswoman Elizabeth Holtzman
Chairwoman
Subcommittee on Immigration, Refugees, and
International Law
Committee on the Judiciary
U.S. House of Representatives
Washington, D.C., 20515

Dear Congresswoman Holtzman:

I appreciate very much the opportunity to respond further regarding H.R. 7118 relating to Foreign Medical Graduates. Unfortunately, your letter of May 20, 1980 was delayed in the mails and not received here until the last few days. Perhaps this is due to a protracted employee strike which we have been experiencing at the University of Pittsburgh. The answers to your questions have been accomplished as succinctly and pointedly as I was able and I hope they do not arrive too late to be of some guidance.

Sincerely yours,

A handwritten signature in dark ink, appearing to read "J. D. Myers".

J. D. Myers, M.D.

JDM/rt

Enclosures

cc: John A. D. Cooper, M.D.

What role should teaching hospitals play in meeting the needs of the community? Have they paid sufficient attention to this problem?

First, it must be made clear that teaching hospitals are of two types: those significantly affiliated with or parts of medical schools and those which are not. The vast majority are in the former category.

The primary mission of a medical school and its affiliated hospitals is medical education at the undergraduate (medical student) level, at the graduate (resident and fellow) level, and to a lesser degree at the post graduate (continuing medical education) level. The hospital programs of a medical school must be in consonance with its undergraduate and graduate medical programs. This precludes a medical school from taking on very large responsibilities for community medical care. The school does have the responsibility to make sure that its hospital and ambulatory programs include a realistic cross-section of the health problems of the community so that students, residents and fellows are appropriately exposed and experienced in these. The schools can thus serve as "laboratories" for the development and demonstration, as well as hopefully the inspiration, for effective, modern and empathetic systems for the delivery of care. Each school must study and understand the needs of its community. It must be realized that different schools have differing communities; some are quite local in scope whereas others, in addition to local responsibilities, leave regional or national impacts. It must be admitted that some schools have better met their local responsibilities than others.

A basic point, which requires reemphasis, is that the total clinical program of a medical school must be proportional to educational needs at the various levels. Any clinical program truly excessive for educational needs hampers the quality of education.

Is there a difference that can be ascertained between the quality of programs in affiliated and non-affiliated institutions?

This question can be answered from the experience of the various residency review committees. The author served for six years on the Residency Review Committee for Internal Medicine, including two years as its Chairman. There can be no question from such reviews of the qualifications for accreditation of residencies that in general affiliated programs are superior. As Chairman of the Liaison Committee on Graduate Medical Education the author observed comparable differences in the residency programs of other specialties than internal medicine.

To what extent does the medical educational community take into account the needs of communities in directing their programs?

This question is partially answered in response to the first question. The educational community has the responsibility to recognize community needs and to investigate and study those needs as indicated. Appropriately sized, often pilot, programs of quality should be mounted to demonstrate how community needs can be met effectively. Learners at all levels should be involved in these programs.

Why does there continue to be a need for pediatricians which positions were formerly held by FMGs?

To our knowledge there is no significant national deficit of pediatricians. In fact, with the increasing production of medical school graduates, there is predicted to be an excess within this decade. The problem with pediatricians is one of distribution. Where there is a serious local deficit of pediatricians, there are usually local reasons for such — inadequate or poor medical facilities, unattractive communities for raising a family and schooling, etc. The municipal hospitals of New York City and the institutions with which they are affiliated must look at themselves first.

How are the nation's medical educational goals determined; is it quantity and quality regardless of the needs of the community?

This question can be answered by referring to the matter of the production of primary care physicians during the past five years or so. The nation's medical schools, teaching hospitals, and the young men and women in training have all responded to increase significantly the output of primary care physicians, predominantly in the specialties of general internal medicine, general pediatrics and family practice. The increase in output is still continuing and overall more than half of medical graduates are entering the above named specialties. The increased production of primary care physicians was a response to a perceived need, by the institutions and the trainees, of the national community. The problem of distribution, as mentioned above in regard to pediatricians, is another issue.

The position of the AAMC on these matters can be found in a recent document of the organization, "Graduate Medical Education: Proposals for the Eighties."

What recommendations do you have for improving programs, and who should assume the financial burden?

Private teaching hospitals affiliated with medical schools, by and large, do not have serious problems with the quality of their programs or with financing as compared to municipal, tax supported hospitals. The financial costs of graduate medical education in affiliated private teaching hospitals is borne (a) partially by medical schools, usually in the form of faculty salaries and support services for faculty but (b) largely by the hospitals mainly from third party payments — private insurers, Blue Cross, Medicare and Medicaid. Since the overwhelming majority of hospitalized patients have third part coverage, the hospital's proportion of the costs of graduate medical education is quite evenly spread as a "tax" over a very large percentage of the population. State and federal governments contribute support via Medicaid and Medicare and, to a much lesser degree, through grants in support of special programs.

Municipal, tax supported teaching hospitals may receive some support from affiliated medical schools. However, those hospitals are at a disadvantage regarding third party support. In serving a large indigent population, the proportion of Medicare coverage is less. State governments have generally been restrictive in the amount of support for Medicaid and alien noncitizens or aliens of illegal entry often do not qualify. Legislation to extend Medicaid support, particularly at the federal level, would greatly help the financial status of municipal hospitals. The latter's financial destitution is their greatest barrier to the betterment of their programs in graduate medical education. An alternative is to abolish municipal hospitals, as in Pittsburgh, and to spread the patient care load among private institutions. If this is to be done adequate governmental reimbursement of the private hospitals is required, or otherwise they would be dragged down just as are the municipal hospitals today.

To what extent are the medical colleges training U.S. graduates to serve all strata of society?

Medical schools should assure that medical students have some experience with medical care as provided to the various strata of society. By and large this is accomplished. The schools, however, can play only an instructive role in this regard and through exposure and emphasis interest students in medical practice among the lower strata. The training as medical students and residents, particularly those in the primary care specialties is entirely adequate for this purpose. In a free society, a democracy such as ours, compulsion to practice in a given stratum is not possible nor is it desirable. A point of interest here is that blacks and other disadvantaged students upon completion of their training do not choose to practice among the lower strata any more than do their traditional Anglo-Saxon counterparts.

Why have U.S. medical graduates not chosen to go into primary care specialties? How can this be remedied?

More than half of all medical school graduates are now entering residencies in preparation for a primary care specialty. This was not true in the '60s and early '70s when there was greater emphasis on subspecialization. Students have perceived the societal need for generalists and have made part of the transition on their own. Medical schools are placing greater emphasis on primary care. Medical school faculties are changing with the introduction of a greater number of capable generalists who can serve as role models for the students and residents. If present trends continue, there will be adequate numbers of primary care physicians within the decade. No additional remedy is desirable but the medical schools should keep the matter under close surveillance.

What steps has the AAMC taken to improve the quality of graduate medical education?

The AAMC is a tripartite group made up of a Council of Deans, a Council of Teaching Hospitals and a Council of Academic Societies (American College of Physicians, etc.). All three groups have a strong concern for

quality graduate medical education. The AAMC is one of the parent organizations of the Liaison Committee on Graduate Medical Education, which accredits all residency programs. A task force of the AAMC has just recently and largely completed its work which is published in a report "Graduate Medical Education: Proposals for the Eighties."

AAMC stands, proposals and accomplishments in the field are too numerous to detail but quality is consistently a byword in its activities. To select one example, the AAMC recommendation that the FMG waiver not be extended is an action to improve quality, assuming that the necessary and clearly indicated corrective measures are taken in programs which heavily attract FMGs.

JDM/rt


AMERICAN MEDICAL ASSOCIATION

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 JAMES H. SAMMONS, M.D.
 Executive Vice President
 (751-6088)

July 15, 1980

The Honorable Elizabeth Holtzman
 Chairperson
 Subcommittee on Immigration, Refugees
 and International Law
 Committee on the Judiciary
 2137 Rayburn House Office Building
 Washington, D.C. 20515

Dear Representative Holtzman:

Enclosed are responses to written questions submitted by the
 Committee to the American Medical Association as a result of the
 appearance by Leonard D. Fenninger, M.D., at a hearing held on
 May 14, 1980 concerning foreign medical graduates and your bill,
 HR 7118.

If the American Medical Association can be of any further
 assistance in this matter, please feel free to contact us.

Sincerely,

James H. Sammons, M.D.

JHS/jcl
 Encl.

1. How much supervision is given to those residents performing health care services?

There is no fixed standard applicable in all situations. The degree of supervision appropriate in an individual situation depends on the experience of the resident, how long he has been a resident in the special field of his choice, the type of specialty and the type of institution offering the residency program. Supervision is sufficient when it is adequate to assure safe, timely and effective care of the patient, to allow the resident physician to increase his ability to make independent clinical judgments and to develop the knowledge and skills for independent practice upon completion of his training. As skills and knowledge increase, direct supervision declines.

2. Will the forecasted surplus of medical doctors "spill over" to undesirable geographic or specialty areas?

The question erroneously assumes the correctness of those forecasts made of a "surplus" of physicians. The principal concern of the public, of government and of the medical profession is to assure that medical services of high quality are available to persons who need them when they are needed. There is not a surplus of medical services at the present time and there is no data that there will be a surplus of medical services provided by physicians in the near future.

The question also suggests the propriety of designating certain specialties as "undesirable." The "undesirability" of particular specialties in medicine and situations and locations within which physicians practice varies with individuals, the state of the art of medicine, family situations, the cultural, social and economic circumstances of nations, regions, states and localities. Experience in most fields and in most nations indicates that the number of variables influencing professional careers and choice of places to practice them are so great that actual predictions as to the specialty or geographic areas in which professionals will practice are unreliable. In our view, it can be assumed that as numbers of physicians increase, there will be additional movement into underserved areas.

3. In the past, FMGs have played a significant role in filling the needs of patients in primary care specialties. Will U.S. medical graduates seek these positions?

The choice of specialty and location of FMGs has depended on the opportunities available to them as compared with the opportunities available to U.S. citizens who attend U.S. medical schools. FMGs

have not tended to provide a disproportionate share of "primary medical care" as compared with U.S. citizens who have graduated from U.S. or Canadian medical schools. It is very likely that as the numbers of U.S. citizens graduating from U.S. schools increase, the ratio of U.S. medical graduates filling residency positions will also increase.

4. Should the number of residency programs nationwide be reduced so that medical graduates would have to serve in those areas where the need is greatest?

No. Residency programs consist of advanced education in medicine through the provision of medical service. They are recognized as providing adequate education and supervised clinical practice when they meet minimal educational standards and are accredited. Their organized educational components differentiate them from the independent practice of medicine. The number and types of residency programs should be determined on the basis of whether they meet the educational and service requirements which are established as the basis for recognition of residency programs when they seek accreditation.

5. Is there any truth to the belief that FMGs are paid less and work longer hours than U.S. medical graduates?

The AMA has no information that would indicate a pay differential for resident physicians based on whether they are graduates of U.S. and Canadian or foreign medical schools.

6. A recent article in the Wall Street Journal stated there are increasingly more Canadian doctors establishing themselves in the U.S. Do you know where these doctors are practicing and are you concerned about this development?

The AMA does not have information as to the number of Canadian physicians who have emigrated to the U.S. The AMA is concerned that persons residing in the U.S. receive good medical care when they need it. Graduates of Canadian medical schools have successfully completed a course of medical education that meets the same educational standards that are applied to U.S. medical schools.

7. Is there a role for the physician extender? Will there be similar problems, as there is with doctors, with attracting such practitioners to the innercity?

Persons who have special preparation for the care of the sick and for the prevention of disease have long worked with physicians in providing services to patients. They work effectively and provide essential services. The ultimate responsibility for the diagnosis and treatment of diseases in persons who have them rests with physicians because of their education, training and experience. This responsibility is legally recognized through medical practice acts and licensure.

The problems which beset many residents of inner cities extend to all human services, not just to medical and other health care. The factors which limit the availability of services to inner city residents affect the "physician extenders" as well as the physician. Since "physician extenders" work with physicians, their ability to render medical services depend on the availability of physicians and they cannot be looked upon to resolve the social, economic, cultural, educational or health problems of inner city residents.

8. How much residency time is devoted to servicing the hospital's needs; how much of that time is devoted to educational training?

Education and medical service are inseparable in the education of the resident physician. Any attempt to ascribe a percentage of the resident's time to education as opposed to service would be arbitrary at best. The primary responsibility of the resident as a physician is to patients and their well being. The resident physician's ability to fulfill this responsibility depends on the number of patients for whom he/she provides care, the resident's experience, knowledge and skills and the nature of the patient's illness. As a responsible practitioner of medicine, the physician has an obligation to learn and to apply all the knowledge and skill which he/she can acquire.

9. What states do you see as still having a disproportionate share of foreign medical graduates in residency programs? In which specialties?

In the sense that the number of FMGs are not evenly distributed, either based on total state population or on the basis of the number of residency positions within the states, it probably could be said that almost all states have "a disproportionate share of foreign medical graduates in residency programs" in that some states have more than their proportionate share and some states have less.

It is difficult to define, much less determine, what a "disproportionate share" of FMGs is in any program or in any locality or specialty. The issue is whether a residency program provides good education and clinical training for all residents accepted in the program, regardless of their national or educational origins, so that they may become physicians who have the knowledge, skills and judgment to provide safe, effective and timely medical care.

Statement of the American Hospital Association

TO THE SUBCOMMITTEE ON IMMIGRATION,
REFUGEES AND INTERNATIONAL LAW
OF THE
HOUSE JUDICIARY COMMITTEE
ON H.R. 7118, A BILL RELATING TO
FOREIGN MEDICAL GRADUATES

MAY 21, 1980



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STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION
 TO THE SUBCOMMITTEE ON IMMIGRATION,
 REFUGEES AND INTERNATIONAL LAW
 OF THE
 HOUSE JUDICIARY COMMITTEE
 ON H.R. 7118, A BILL RELATING TO
 FOREIGN MEDICAL GRADUATES

MAY 21, 1980

The American Hospital Association, which represents over 6,100 member hospitals and health care institutions as well as more than 30,000 personal members, is pleased to have this opportunity to present its views on H.R. 7118, a bill that would amend the Immigration and Nationality Act with respect to the admission of certain aliens for graduate medical education or training programs.

Hospitals are sincerely committed to the delivery of high quality, cost-effective health services to their patients. This care is provided through a careful balance of physicians, nurses, and allied health personnel. In many institutions, a large proportion of the medical services are provided by medical residents, who are qualified doctors pursuing specialty training. Unfortunately, some hospitals, especially those located in urban areas, have experienced difficulties attracting sufficient numbers of United States medical school graduates to their graduate medical education programs. As a result, these institutions have often trained a significant number of alien graduates of foreign medical schools.

In recent years, however, there has been a growing perception that the supply of physicians in the U.S. is rapidly approaching sufficiency and that it no longer is appropriate to encourage actively foreign medical graduates (FMSs) to enter the country. Congress addressed this issue when it enacted Public Law 94-484, the Health Professions Educational Assistance Act of 1976, which, in part, amends the Immigration and Nationality Act to restrict the entry of alien

physicians into the U.S. Since then, the number of FMGs has steadily declined from a high of 14,300 (23.3% of all physicians in graduate training programs) in 1976 to 9,200 (15.4%) in 1978, the most recent year for which data are available.

Substantial Disruption Waiver

In order to give hospitals adequate time to reduce the numbers of FMGs in residency positions and to recognize short-term medical service needs in certain communities across the country, Public Law 94-484 amended section 212 of the Immigration and Nationality Act to permit teaching hospitals to request a waiver of the provisions limiting the participation of FMGs if it is shown that exclusion of an alien medical graduate from the program would cause a "substantial disruption" in the health services provided by the hospitals. This waiver provision expires December 31, 1980. Section 1 of H.R. 7118 would extend the waiver to December 31, 1982, with an additional one-year extension if the Secretary of Health and Human Services finds that a program has substantially reduced its reliance on alien physicians.

The AHA strongly supports this proposed extension. The total number of FMGs has steadily declined from 5,090 in January, 1977 to 2,300 to date. As of March 1980, only seventy residency programs had requested application of the waiver; however, its continued availability is of critical importance to certain major urban health institutions. Many hospitals, both public and private are experiencing severe financial difficulties as a result of the volume of uncompensated services provided to urban residents who do not have health insurance coverage and are ineligible for public programs. A significant side-effect of this problem is the decreased ability of these hospitals to retain medical staff and to maintain graduate medical education programs. As financial conditions worsen, salaries in these hospitals cannot keep pace, and the ability of the institutions to maintain the equipment and support services required by physicians in specialty practices becomes severely limited.

A recent New York Times editorial noting that the termination of the "substantial disruption" waiver would intensify the hospital financial crisis in New York City stated that hospitals would be forced either to reduce services or to incur further costs in attempts to attract U.S. physicians to replace the

foreign physicians-in-training. Those most likely to suffer, the editorial concludes, would be the poor who rely on housestaff as their family physicians.

We also support the provision in section 1 that would extend the length of time for which FMGs are permitted to come to the United States for training from the existing two years to the time typically required to complete the residency program. This proposed extension would allow the residents adequate time to meet eligibility requirements of the American Board of the Medical Specialties, requirements that reflect the necessary training period to achieve competency in a designated specialty.

National Health Service Corps Provision

Section 2 of H.R. 7118 would designate as health manpower shortage areas public or private nonprofit hospitals with residency training programs that have received waivers within the past twelve months. These hospitals would then be eligible for National Health Service Corps (NHSC) physicians, who could perform their obligated service as a practitioner or as a resident in a graduate medical education program (under sections 333 or 752, respectively, of the Public Health Service Act). Further, the cost-sharing obligation of the hospital would be limited to a salary equal to that which was paid to FMG residents.

The AHA supports these proposals. In our view, automatic designation of FMG-dependent hospitals as health manpower shortage areas to make them eligible for assignment of NHSC personnel could help alleviate the problem of reliance on FMGs. Although in the recent past many urban hospitals have applied for shortage area designation, those designations have not been forthcoming. We are hopeful that an automatic designation process will eliminate this problem and will, in addition, encourage physicians to establish practices in underserved urban areas, thereby helping to ameliorate the chronic physician shortages in these localities.

We particularly welcome the favorable cost-sharing provision since, as we have already noted, many of these institutions are in financial jeopardy as a result of the large amounts of uncompensated care they provide to the poor and near-poor. We would note, however, that the cost-sharing provision would become effective only if a hospital can demonstrate that the position available for a

Corps member is attributable to the termination of "one or more positions filled by an alien graduate of a foreign medical school." We assume that the intent of this provision is not to eliminate approved residency slots, but rather to require the substitution of U.S. medical school graduates for FMGs in existing residency positions. Institutions must not be forced to reduce their reliance on alien physicians by terminating approved residency positions. The appropriate number of positions for any residency program is and should continue to be determined by the individual hospital in cooperation with the Liaison Committee on Graduate Medical Education, taking into account the resources of each institution, the characteristics of the patient population served, and the availability of teaching physicians. To do otherwise could require some institutions to experience serious physician shortages that would have an adverse impact on the delivery of needed care and significantly increase the cost of that care by requiring contractual arrangements with physicians from established private practices.

The American Hospital Association believes that the provisions of this bill are important to the continued ability of certain hospitals to provide needed health services to their communities. We urge this Subcommittee to give favorable consideration to H.R. 7118. We will be happy to provide any additional information that you may require.

STATEMENT

BY

CESAR M. MADARANG, M.D.

Washington, D.C. Internist and Executive Director,
Association of Philippine Practicing Physicians in America
on

H.R. 7118

A bill to amend the Immigration and Nationality Act
with respect to the admission of Alien Physicians for
graduate medical education

Before the Subcommittee on Immigration, Refugees and

International Law

Committee on the Judiciary

Washington, D.C., May 28, 1980

I appreciate this opportunity to say a few words on the proposed H.R. 7118 seeking to amend the Immigration and Nationality Act with respect to the admission of alien physicians for graduate medical education.

I have been involved and active in foreign medical graduate affairs for a number of years. I am currently in private practice of internal medicine at St. Jude Medical Center, 2802 Rhode Island Avenue, N.E., Washington, D.C. 20008 since 1963. I am the executive director and past president of the Association of Philippine Practicing Physicians in America. (There are 14,000 Filipino physicians practicing in the United States today, many of whom are members of the APPPA). I am also a member of the Board of Trustees of the American College of International Physicians, an organization consisting of many FMGs dedicated to improving international health; a member of the Board of Directors of the District of Columbia Political Action Committee for the last three years. I have served as a member of the American Medical Association's Board of Trustees Ad Hoc Committee on Foreign Medical Graduate Affairs for two years.

The issue before the Subcommittee has to do with FMGs:

- The FMGs who are here, what and how they have been doing, how their presence relates to both the health care and physician manpower in this country.
- The FMGs who have yet to come to this country, under what conditions they may come, how long they can train, how long they can stay.

For years the FMGs who are here have become an integral part of America's health network, providing health care to the diseased and the disabled, many in underserved, isolated, small communities usually shunned by American doctors.

About 80% of these FMGs are in four primary care specialties (medicine, general surgery, pediatrics, obstetrics-gynecology) and four non-primary care fields (pathology, psychiatry, anesthesiology, rehabilitative medicine)

historically unpopular with American MDs.

The Americans served by these FMGs are the same people served by Members of Congress. You serve them by enacting laws for their welfare; we serve them by looking after their well-being.

That was the picture of the FMGs in America until 1976 when the Public Law 94-484 was enacted to protect the physician manpower in this country and to insure that only medically and English-language qualified FMGs could enter as immigrants or non-immigrants.

When the law was passed, however, it created unfortunate, adverse effects for thousands of FMGs.

e I am referring to FMGs who were already here when the law was passed, most of whom were and still are administering health care in areas where the need is critical.

e I am referring to those FMGs who have for years made this country their home, who have made special efforts to become part and parcel of the American way of life, the American free society, the American free-market economy.

e I am referring to FMGs who dutifully find time for acculturation and continuing education programs in their appreciation for the American commitment to human values and development.

e I am referring to FMGs who have elected to remain in America and serve, many of whom have children who are American citizens by virtue of birth.

With the enactment of the public law also came criticisms of all sorts about FMGs: FMGs do not know how to diagnose illness. FMGs do not speak English well enough to communicate. FMGs do not relate well. FMGs tend to isolate themselves.

Those, of course, are more exceptions rather than the rule.

The rule is, because medical graduates from foreign countries always try to do just a little bit harder in keeping pace with American colleagues

they excel in their profession and practice, sometimes exceeding that which is normally expected of them as physicians. To cite a few examples:

- The head of cardiac surgery at the Washington Hospital Center here in the nation's capital is an FMG.
 - The chief of pediatric nephrology at the Children's Hospital of Newark in New Jersey is an FMG.
 - The chairman of the department of anesthesiology at the University of Texas Medical Center in Houston is an FMG.
 - The chairman of urology at the New York Medical Center in New York City is an FMG.
 - The director of pathology and laboratory medicine in the Little Company of Mary Hospital in Evergreen Park, Illinois is an FMG.
 - The chief of psychiatry at Lyons VA Medical Center in New Jersey is an FMG.
 - The assistant dean of continuing medical education at Georgetown University in Washington, D.C. is an FMG.
 - The chairman of pediatrics at Rio Hondo Memorial Hospital in Downey, California is an FMG.
 - The director of emergency medicine at Overlook Hospital in Summit, New Jersey is an FMG.
 - The chief of alcoholism and drug program at Brockton VA Hospital in Massachusetts is an FMG.
 - The chief of pediatrics in Georgetown University School of Medicine in D.C. is an FMG.
 - A goodly number of associate and full professors in American teaching hospitals and medical colleges are FMGs.
 - Many physicians who set up practice in low-income areas or are with the staffs of municipal hospitals often unattractive to American doctors are FMGs.
- To impose restrictive measures on FMGs therefore, whether enforced in a

two-year or five-year phase-out program, is not only unfair to FMGs but unrealistic from the American point of need for the services of these FMGs.

Statistics show that loss of FMGs will be severely felt in the northeastern and north central states where hospitals depend largely on FMGs. About 58% of interns and residents in New Jersey teaching hospitals are FMGs, in Connecticut the figure is more than 70%, and in the states of Illinois, Michigan, Ohio, Maryland, Delaware and New York the housestaff is 50% FMG.

The H.R. 7118 provisions to remove the specialty requirement as a condition under which affected FMGs may stay in the U.S., and to increase the training time to what is actually needed to complete a training program, are helpful. We certainly hope these provisions are approved as submitted.

But the foreign medical graduate issue, we believe, goes beyond whether FMGs who passed the VQE may stay, whether FMGs who can communicate with their patients may practice, or whether FMGs who promise to return to their home countries at the completion of a training grant may enter the U.S.

The true and fundamental issue here is one that involves America's expressed commitment to help other nations wipe out poverty, sickness, ignorance, illiteracy.

For America to shut her door to those desiring to come and gain, not only additional necessary education but exposure to America and all that America stands for, is tantamount to closing the door to America's potential friends, potential supporters, potential allies abroad.

With that in mind, I respectfully suggest that a study be made to see how maintaining a certain number of FMGs training and serving in the United States, year after year, would be of benefit to the American people at the same time that America rightfully protects the interest of U.S.-produced doctors.

This way, you have a number of FMGs who stay and serve in this country, and you have a number who go back to serve their country and their people.

Statistics have shown that many of those who go back become leaders in their government, their industries, and in other forms of service for their country. Expectedly, because of having been exposed to the American way, the American system, the American life, these FMGs leave the American soil as friends of America -- friends that America can count on in time of peace and in time of crisis.

As leader of the free world, America simply cannot afford to be indifferent and unresponsive to the plea of other peoples hungry for knowledge, education and skills.

Indeed what America has been doing in the field of educational exchange -- by opening her door to these peoples of foreign countries who wish to acquire needed education and skills for their countries' development and advancement -- is such a very small investment compared to the big dividend of support and friendship received in return.

I conclude with a question and a suggestion.

My question: If America desires to reduce and eventually phase out the FMGs -- from 3076 in 1978 to 1100 by 1984 -- does America factually want to do so even if it meant losing potential friends and supporters around the world that America no doubt would need at one time or another if she is to remain a leader of the free world?

My suggestion: as I mentioned earlier, perhaps the federal government could authorize an in-depth study to find out whether maintaining a constant number of FMGs training and serving in the United States each year would help or hurt the American people.

Again, I am grateful, and honored, for the opportunity to speak on behalf of foreign medical graduates.//

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May 28, 1980

Preserving our international role in postgraduate medical education

by William H. Mosberg, MD, FACS, Angelo P. Angelides, MD,
George J. Hayes, MD, FACS, and Joseph P. Evans, MD, FACS

Authors' note...

This article is designed to provide information concerning the impact of Public Law 94-484 and Public Law 95-83 on the leadership role of the United States in postgraduate medical education; to discuss inevitable adverse effects on the position of the United States in international relations; to suggest changes in legislation that permit proper specialty training; and to emphasize the wide range of short-term opportunities for study available under the J1-Visa without the requirement of the Visa Qualifying Examination.

Though considerable concern has been expressed over the possible disruption of medical services by decreasing abruptly the number of foreign physicians coming to the United States for residency training,¹ less attention has been paid to the deleterious effects on our position as medical educators in the world today. We write not solely as members of the medical profession, but very particularly as citizens who recognize the adverse impact of the legislation on international relations.

After World War II, the United States was generally recognized as the predominant force in postgraduate medical education. Free of the destructive effects of war, affluent, strongly supported in research efforts by foundations and government, and possessed of a hospital funding system that provided increasing financial support of resident staff, the United States (and Canada) served as a magnet for medical graduates the world over. Our capacity to absorb rising numbers of foreign medical graduates (FMGs) was great, a capacity created by our growing population, by a rapid increase in the technological developments of health care, and by the changing attitudes of the public toward the right to adequate medical attention.

Our attitude toward the incoming post-

graduate physicians was characterized as a sincere desire to provide training for individuals destined to use their knowledge and skills in their countries of origin, thus serving the needs of mankind. But soon, many factors began to militate against FMGs returning to their home countries, particularly the length of the training period.² Another factor was the overt need for "hands" to assist in caring for the patient load, particularly in large urban hospitals.³ Another was the opportunity arising from increased public expectations for a sufficient pool of practitioners, expectations unmet at that time by the increased output of North American schools of medicine. With the relaxation of immigration restrictions to meet this perceived need for trained physicians, a problem of considerable magnitude was created. The United States found itself accused of causing a "brain drain." To some extent, the accusation was justified, for in some instances individuals took advantage of liberal immigration policies rather than return to countries where opportunities seemed less promising. In many instances our local profession was enriched. (As noted by Dublin,⁴ in the last forty years six of the 17 U.S. Nobel prizewinners in medicine were FMGs.) On the other hand, for decades many countries have been overproducing physicians in the expectation that some will emigrate. Indeed, this overproduction of physicians is one of the gravest problems developing countries now face, for as free migration of their highly educated young people becomes more and more restricted, dissatisfaction and political

Dr. Mosberg is clinical professor of neurosurgery at the University of Maryland School of Medicine in Baltimore; Dr. Angelides is senior vice-president for medical affairs at Cooper Medical Center in Camden, New Jersey; Dr. Hayes is a neurosurgeon in Alexandria, Virginia; and Dr. Evans is ACS Assistant Director, International Liaison. Reprints are available from the Communications Department of the College.

"In an effort to address the multifaceted aspects of the FMG situation, federal legislation has inadvertently jeopardized the role of the United States in international medical education."

unrest at home will inevitably follow. Increased expenditures for medical education might better be diverted to the development of a medical infrastructure.

Picture changes

Rather abruptly, the postgraduate medical education picture in the United States underwent significant change. The number of U.S. medical schools rose from 87 in 1963 to 116 in 1976; in the same period, the number of graduates from those schools rose from 7,336 to 13,607, an increase of 84 percent.⁶ The number will soon increase to approximately 17,000. At present, there are some 18,000 positions available each year for postgraduate studies,⁶ leaving a slack of approximately 1,000 positions in regularly accredited residencies. With present pressure to increase the number of family-practitioner training positions, the availability of long-term residency positions is diminishing for U.S. graduates, as well as for U.S. citizens returning from abroad and qualifying for advanced training.

Meanwhile, because of the need for medical manpower in the United States, the conversion of J1-Visas (the Exchange Visitors' Visa) into Immigration Visas has become subject to free interpretation. Between 1962 and 1975, more than 47,000 foreign physicians migrated to the United States. They came from 100 nations and some 400 medical schools.⁷ This situation led to the June 1976 Report of the Coordinating Council on Medical Education, "Physician Manpower Distribution: The Role of the Foreign Medical Graduate."⁸ One of the recommendations in that report is contained in Section 7 (page 8):

"That the duration of graduate medical education in the United States of all exchange visitor physicians be specified in advance of entry into such training, be limited in general to two years or less, and be subject to extension only on the request initiated by the governmental and institutional or agency sponsor in their country of origin assuring them of employment on completion of the extended training period."

The legislation subsequently enacted by Congress proved more restrictive than that

recommended by the Coordinating Council on Medical Education. Public Law 94-484, the Health Professions Educational Assistance Act of 1976, was signed into law on October 12, 1976. It states in Section 2(c), "The Congress further finds and declares that there is no longer an insufficient number of physicians and surgeons in the United States such that there is no further need for affording preference to alien physicians and surgeons in admission to the United States under the Immigration and Nationality Act."

Thus, the law abruptly ended the easy conversion of J1-Visas to Immigration Visas. Further, it seemed to stipulate that any individual seeking postgraduate medical education in this country must have passed, prior to entry, Parts I and II of the National Board examinations (or its equivalent as determined by the Secretary of Health, Education and Welfare), and must have demonstrated competence in oral and written English. In developing the equivalent of the examination offered by the National Board of Medical Examiners, that Board was asked to draw on its special educational resources. The National Board prepared the examination. Its administration was delegated to the Educational Commission for Foreign Medical Graduates as an activity separate from the familiar ECFMG examination.

In addition, the law stipulates that: a) the applicant for training may be accepted only in programs offered by medical schools and their affiliated teaching hospitals; b) the applicant commit himself to return to his country of origin upon completion of the training period; c) the sending country indicate the need for the special skills to be acquired; and d) the duration of training be limited to two years, with a third year allowable at the request of the country of origin.

Review of the legislative history of P. L. 94-484 clearly indicates the intent of Congress to eliminate the easy conversion of the J1-Visas to Immigration Visas and to require the FMG to satisfy the routine immigration procedures applicable to his particular nationality. At the same time, the law gave permission for an increase of 25 percent in the number of residency openings above the annual

FMGs: THE LAW

output of physicians trained in U.S. medical schools.

Critique of the legislation

An essential element in legislative action relevant to FMGs is the recognition that we, as an affluent favored nation, have a moral obligation to offer, within limits tempered by intelligent and reasonable self-interest, our superb medical opportunities to the graduate students of developing countries. Today many countries must still send physicians and surgeons abroad for specialty training. For example, in a letter written a little more than one year ago,⁸ Dr. Samuel P. Asper, then Dean of the American University of Beirut in Lebanon said, "There are now 38 medical schools in Arabic-speaking nations of the Middle East and a third of these opened only in recent years. Most schools and medical centers are short staffed . . ." Each of these medical schools will require a fully staffed and fully credentialed faculty. The needs of these and other nations must somehow be met. Canada has restricted its number of residency training programs to the point that there will be few, if any, opportunities for foreign medical graduates. Latin America cannot fill the void completely, and though local centers are now being developed rapidly, there are, for economic reasons, limitations to what can be accomplished. The role played in the creation of good international relations and mutual understanding by individuals trained in medicine in this country cannot be overestimated.^{9, 10}

Included among individuals who desire to come to the United States for graduate training are mature clinicians who find themselves discouraged from applying because of the severity of the Visa Qualifying Examination (VQE). Making this examination equivalent to the National Board examinations is in fact impossible since most North Americans take Part I of the National Boards at the end of their second year in medical school, whereas applicants for postgraduate medical education are faced with the examination two or more years later. The high failure rate in the VQE examination, 75 percent in 1977 and 70 percent in 1978, leads many potential candidates to the easier course of seeking training in countries that have not erected high hurdles. For the past two years, there has been a perceptible shift away from the United States for training. The evidence is largely anecdotal, but nonetheless reliable. France, England, Spain, and West Germany are

among the countries to which postgraduate students are turning. Soviet-bloc countries are taking advantage of the vacuum. Current estimates show that no fewer than 160 Panamanians are studying medicine in the Eastern-bloc countries at the undergraduate level; we do not know how many there may be at the graduate level. Ecuadorian and Peruvian students are also being drawn behind the Iron Curtain by attractive fellowships.

Trainees, particularly those at the postgraduate level, inevitably turn to their training countries for ancillary needs. Thus, we may anticipate a sharp reduction in requests for North American products: drugs, medical and surgical supplies and equipment, radiological diagnostic and therapeutic equipment, and publications. The potential loss to the United States may well prove formidable. The chain has already been broken and it will require years to re-establish old connections.

Suggested modifications in the laws

P.L. 94-484 and its amending act P.L. 95-83, which became effective August 1, 1977, have obviously achieved their primary objective of sharply limiting physician immigration by eliminating the favored status that permitted physicians to turn J1-Visas into Immigrant Visas. Regular, nonfavored, and therefore restrictive routes of immigration are still open to those individual physicians who desire to enter this country as immigrants.

The primary problem with the present laws is the restriction placed on FMGs in many specialty fields to return to their sending countries before they can complete proper training in their specialty.

We need to differentiate between two groups of postgraduate students. The first group is made up of individuals from countries unable, because of lack of qualified educators or adequate resources, to provide full specialty training. The second group is made up of individuals, often very experienced clinicians, who have completed specialty training at home or elsewhere and who desire to come to this country for training in special techniques. Examples might be the established pediatrician interested in neonatology or a surgeon interested in learning how to use an operating microscope.

Members of the first group, those seeking full training in a specialty, are usually recent medical graduates who are embarking on a prolonged period of postgraduate study, which in some instances may last six or seven

18 *American College of Surgeons*

years. Only two specialties, pediatrics and general practice, require a minimum of three years of training. All others require longer periods. For centers in the United States to train specialists to an inferior standard would subject returnees to justifiable criticism that they are inadequately trained, and would provide a basis for adverse judgment of our educational methods. Available openings should of course be in properly recognized centers, approved by proper specialty boards and the Liaison Committee on Graduate Medical Education. The role of the boards and the LCGME cannot be overemphasized since they have maintained quality standards in each of the specialties.¹¹

The second group includes experienced individuals who seek short-- periods of training in advanced specialization, -- six or twelve months and, less frequently, up to 24 months. This group may include individuals who have recently completed residency training in their home country or elsewhere, or more experienced individuals who desire to learn about recent advances in their particular field.

Short-term opportunities

The present legislation does permit J1-Visa applicants to come to the United States for brief periods without taking the VQE, provided they come for observation, consultation, teaching, or research and do not assume responsibility for patient care. These individuals can be appointed as fellows, and their needs met by allowing them to attend ward rounds, clinical conferences, journal reviews, and related activities devoid of direct clinical responsibility. Many of their needs to acquire technical skills, particularly surgical skills, can be met by participating in animal-laboratory activities. In fact surgeons may assist in the operating room, but they may not assume direct responsibility for patient care. It is anticipated that the International Communication Agency will closely monitor these individuals and severely restrict the institutions at which they work if violations occur.¹²

The question arises whether or not experienced clinicians who are seeking highly specialized training opportunities can satisfy their needs in the face of such restrictions. It is reasonable to expect that individuals who wish greater freedom of action and more direct responsibility for patient care meet the same requirements as those coming for full clinical training. On occasion, a regular training program might accept an individual

for supplemental clinical training for a brief time, but the trainee cannot gain credit for medical specialty board certification, a restriction imposed by the laws.

Many people are confused about the limitations surrounding short-term opportunities. Specific questions about guidelines for admission are referred to the Educational Commission for Foreign Medical Graduates, 3624 Market Street, Philadelphia, Pennsylvania, 19104, U.S.A.

The *Federal Register* of March 31, 1978 (page 13505, Vol. 43, No. 63) notes an entry restriction for those seeking to "receive graduate medical education and training, which generally consists of a residency or fellowship program involving health-care services to patients." However, a distinction is made between individuals coming for training that involves patient-care services and individuals

"Present legislation does permit J1-Visa applicants to come to the United States for brief periods without taking the VQE."

not assuming direct responsibility for patient care. The regulations read, "It should be noted that specific requirements of law which apply to physicians who come to the United States to receive graduate medical education or training do not apply to alien physicians who come to this country as exchange visitors to observe, consult, teach, or conduct medical research." The eligibility requirements for pursuit of "a program involved with observation, consultation, teaching, or research, but which involves incidental patient contact" are found on page 13507. Institutions with questions about the requirements should consult the Educational Commission for Foreign Medical Graduates. If the physician does not assume direct responsibility for the care of patients, he or she has considerable freedom to satisfy educational needs and is exempt from the Visa Qualifying Examination.¹³

A legislative proposal

In the United States currently, the number of first-year hospital residency positions is slightly in excess of the number of medical graduates, with the exception of a few specialties, such as anesthesiology and pathology,

FROM THE LAW

where more opportunities exist. Concomitantly the money invested in residency education has either remained constant or been reduced by external forces so that a *de facto* reduction is occurring. The Residency Review Committees are also under pressure to review and accredit more stringently the existing training programs. In line with this description of current conditions, we think the laws should permit: a) postgraduate students to apply for long-term training, and b) short-term postgraduate students, who do not assume full clinical responsibilities and are certified by the ECFMG, to be freed of the VQE requirement. Our proposals should be viewed as a working document, not as a fully detailed plan.

For both long-term and short-term study, the individual's country of origin or his medical organization should, as covered by current regulations, certify the candidate's need for the training sought by the candidate and there should be a clear definition of who is responsible for funding during the entire study period. Furthermore, the candidate must accept the fact that he must return to his country of origin when he completes training.

For long-term training, the law should recognize the training time required by an American specialty board as the determinant of the trainee's length of stay. In turn, the trainee should have successfully completed the stated ECFMG requirements and have passed the Visa Qualifying Examination.

Short-term study should generally not exceed one year. If it does exceed one year for any reason, the individual's country of origin or local medical organization should certify the additional time. Under no circumstances should short-term training exceed two years. The candidate must have successfully fulfilled ECFMG requirements.

Accomplishing the above goals requires the following:

- Identifying acceptable training opportunities in the United States that have been approved by the Residency Review Committees and the Liaison Committee for Graduate Medical Education.
- Publishing and circulating internationally the regulations governing training opportunities.
- Reviewing the individual's eligibility for the type of training requested.
- Placing eligible candidates in a supervised program of study.

- Obtaining proper certifications from the individual's home country and medical organization.

- Obtaining necessary documentation from the state medical licensure boards to permit the training.

- Assuming Exchange Visitor sponsorship and reviewing the appropriate visa.

- Obtaining evidence of the individual's English language competence.

- Arranging for orientation to American medicine and culture.

- Handling the disbursement of funds to the individual if necessary.

In view of its past experience and expertise, we hope that the Educational Commission on Foreign Medical Graduates will accept responsibility for performing these services for the FMG. Funding should be provided by fees collected from those utilizing the services. The cost will vary according to the service provided.

Conclusion

In an effort to address the multifaceted aspects of the FMG situation, federal legislation has inadvertently jeopardized the role of the United States in international medical education. Concurrently, the law will have an adverse effect on medically related industries.

We propose that the laws (P.L. 94-484 and P.L. 95-83) be amended, not to circumvent the intent of Congress to eliminate the easy conversion of the J1-Visa (the Exchange Visitors' Visa) into an Immigration Visa, but rather to permit properly selected candidates to have access to our educational opportunities and thereafter contribute their knowledge and skills to the welfare of their own people. This requires extending the J1-Visa to permit applicants to remain until the completion of the full period of training as determined by the specialty board in their chosen specialty. Thereafter the individuals would return to the sending country.

For those individuals requesting short-term education, a provision in the appropriate regulations governing the J1-Visa already exists which enables them to enter without passing the Visa Qualifying Examination. This provision is little known and little understood. Further clarification will be gladly offered by the Educational Commission on Foreign Medical Graduates, 3624 Market Street, Philadelphia, Pennsylvania, 19104, U.S.A.¹²

(References can be found on page 31)

¹² American College of Surgeons

**A
REPORT**

**OFFICE OF THE
CITY COUNCIL
PRESIDENT**

IS THERE A DOCTOR IN THE HOUSE?

HOW THE LOSS OF FOREIGN MEDICAL GRADUATES
WILL AFFECT HEALTH CARE DELIVERY IN NEW YORK CITY



FEBRUARY 1980

Acknowledgements

This report was authored by Stella Schindler, with the assistance of Barry Ensminger of the New York City Council President's Office. The author is especially grateful for expertise provided by Robert DeCresce, M.D., M.B.A., Assistant Professor of Pathology, Downstate Medical School.

We would also like to thank Council President staff members: Charles Perkins, Lynne Abraham, Denise Duchemin, Susan Solomon and Olka Harbor, for their help.

We appreciate comments provided by Charles Davenport Cook, M.D., Chief of Pediatrics, Downstate Medical Center; Harold Ratner, M.D., Chief of Pediatrics, Greenpoint Hospital; and Hugh Evans, M.D., Chief of Pediatrics, Brooklyn Jewish Hospital; as well as the cooperation of the New York City Health and Hospitals Corporation.

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Additional copies of this report may be obtained at a price of \$3.50 per copy. Please forward check or money order to New York City Council President's Office, City Hall, New York, New York 10007.

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I. SUMMARY

This report focuses on a health care crisis New York City must soon face: a critical doctor shortage in municipal and voluntary hospitals because of new restrictive immigration policies for foreign-born graduates of foreign medical schools. The loss of these foreign medical graduates -- or FMG's -- will impact severely on the delivery of municipal health care services (especially in certain specialties and certain boroughs) and will have important fiscal implications for the City as well.

In 1976 Congress passed the Health Professions Educational Assistance Act, which ended a national policy of preferential treatment for FMG's seeking entry visas to the United States. At that time, FMG's represented 21 percent of the nation's physicians, many of whom worked as interns and residents in urban areas in the Northeast, particularly New York.

The consequences of the new policy did not go unnoticed. A 1978 article in the prestigious New England Journal of Medicine considered the national implications; a study by the New York State Health Planning Commission looked at the FMG situation statewide. (Some of their respective data are cited in this report.) But despite these studies, New York City took little action to confront the impending problem. This report, which has been and will continue to be used as a lobbying tool to press for recommended federal legislation, details how the doctor shortage will impact on municipal hospitals, and breaks down contemplated costs for replacement medical personnel in HHC institutions.

Attracted by New York's cosmopolitan image and the large numbers of teaching hospitals here, FMG's have traditionally concentrated in the City, working in older facilities in poor inner-city neighborhoods usually shunned by their American counterparts.

Foreign medical graduates now hold about 40 percent of all intern and resident positions in New York City. The new immigration restrictions, which take effect after December 31, 1980, are expected to ultimately cut the FMG population by two-thirds, from 3,056 in 1978 to fewer than 1,100 by 1984.

The reduction of foreign physicians will cripple some City hospitals, while barely affecting others. Large, prestigious institutions will continue to recruit the top students from American medical schools, while deficit-ridden hospitals will find their staffs cut drastically. In 12 New York hospitals, FMG's now represent more than 75% of the housestaff (interns and residents) and their departure could result in severe disruptions. The reduced pool of FMG's will cause the greatest problems in facilities run by the Health and Hospitals Corporation (HHC), which trains more than 40% of the foreign graduates in New York. The HHC dependence on FMG's will be felt more in certain specialties -- pediatrics, anesthesiology and gynecology -- and certain boroughs -- Brooklyn, Queens and Manhattan. An extreme example of the FMG loss: FMG's now make up 93% of HHC pediatricians in Brooklyn and the new policy could leave the borough without any children's services in its municipal hospitals.

One option available to HHC would be to replace FMG's with attending physicians and physician extenders, thus driving up medical personnel costs. If this course is followed, the Council President's Office conservatively estimates that costs will rise \$4.4 million in 1981, \$9.9 million in 1982, \$14.4 million in 1983 and \$21 million in 1984.

To minimize the impact of the upcoming doctor shortage, this report recommends that Congress:

- Postpone implementation of the new immigration restrictions until December 31, 1985 giving the City more time to prepare for the reduction of FMG's.

- Allow FMG's entering the country under the new restrictions to stay long enough to complete their training program (usually four to five years). The law now imposes a two year limit.

- Permit National Health Service Corps doctors to use postgraduate training as fulfillment of their service obligation. Under the current law, Corps doctors receive tuition assistance in exchange for payback service in medically-underserved areas only after training is completed. Present law also precludes any Corps service in municipal hospitals.

In addition, New York City should:

- Intensify its recruitment of American trained physicians, many of whom attended medical schools in the city.

- Step up recruitment of American graduates of foreign medical schools, many of whom are originally from New York.

- Reduce surplus housestaff positions.

II. HISTORY

Over the past two decades, foreign-born graduates of overseas medical schools have played an increasingly prominent role in the delivery of health services in the United States. They often serve in inner-city hospitals lacking doctors and enter specialties, such as pediatrics, gynecology and anesthesiology, which are frequently shunned by their American counterparts.

More than one-fourth of the nation's foreign medical graduates (FMG's) receive training in New York City, which cannot attract enough American graduates to its large number of teaching hospitals in poor and medically underserved neighborhoods.

Concerned about the nationwide shortage of doctors in the 1960's, the federal government encouraged the influx of foreign medical graduates. The usual immigration requirements were waived for foreign doctors in 1965 amendments to the Immigration and Naturalization Act. These amendments exempted foreign physicians from the national origins quota system, thus providing easier access to the United States. Between 1965 and 1975 an average of 7,375 foreign medical graduates entered the country every year, receiving valuable training in U.S. hospitals and providing essential medical services in return.¹

Finding the lucrative earning power of American doctors hard to resist, many FMG's converted their temporary permits into permanent visas to stay in the United States. By 1976, FMG's accounted for 85,000 -- or 21% -- of the nation's 409,000 physicians. Many of these doctors set up practice in low-income neighborhoods avoided by U.S. medical graduates.

As thousands of foreign doctors stayed in the United States, their native countries felt the impact of the "brain drain". Leaders of underdeveloped countries asked why their nations should provide expensive medical school training to young men and women, only to see them leave to practice in the United States.

Most of the arriving FMG's, in fact, were from countries badly in need of their own medical personnel. Of the 10,188 foreign doctors in the U.S. training programs in 1977, 6,559 -- or 64% -- were from physician-poor Asia, and only 1,570 -- or 15% -- were from Europe, where doctors are more plentiful. Over 3,993 -- or 39% -- were from India and the Philippines alone, neither of which has an abundance of doctors.²

Over the past few years, the need for foreign medical graduates in the U.S. has declined, as increasing numbers of doctors graduated from American medical schools. From 1966 to 1977, a 6% annual increase in the number of U.S. graduates helped alleviate the physician shortage of the early sixties, nearly doubling the number of U.S. medical graduates.³ Fears of physician surpluses in some sections of the country were voiced with increasing frequency.

Questions were raised as well about the medical qualifications of the FMG's. Critics pointed out that foreign doctors were not scoring as well as American graduates in standardized tests and questioned their proficiency in the English language. Language and cultural barriers often create obstacles to proper treatment and diagnosis, it was argued. Medical experts acknowledge, however, that standardized tests are not always a fair measure, since they test language proficiency and knowledge of basic medical science, rather than the clinical skills needed on a day-to-day basis. Unfortunately, no comprehensive and reliable study has ever compared the quality of medical care provided by American and foreign medical graduates.⁴

Criticism of the physician "brain drain" from other nations, the increasing supply of U.S. medical graduates and continuing concern about the quality of care rendered by foreign medical graduates convinced more and more policymakers to challenge the federal government's liberal immigration policy for doctors. A series of studies -- by the National Advisory Commission of Health Manpower, the Coordinating Council on Medical Education, the Carnegie Council on Policy Studies in Higher Education, the American Association of Medical Colleges and others -- recommended basic changes in federal policy.

III. FEDERAL LAW RESTRICTS ENTRY OF FOREIGN MEDICAL GRADUATES

Congress responded to these growing concerns by passing the National Health Professions Educational Assistance Act of 1976, declaring the United States self-sufficient in physician manpower and ending the national policy of preferential treatment for foreign medical graduates desiring entry visas.⁵ The new law tightened the educational standards and visa qualifications necessary for entry in an effort to reduce dependence on foreign medical graduates and assure that those who do enter meet the same standards as American graduates. The law essentially placed foreign medical graduates on the same footing as any other alien trying to enter the country.

Specifically, the law:

- 1) Raises the educational requirements for entering foreign medical graduates by replacing the Educational Commission for Foreign Medical Graduates test (ECFMG) with the Visa Qualifying Examination (VQE). The new test, stressing basic medical science and English proficiency, is significantly more difficult. In 1977, when both exams were offered, 33% of the participating foreign medical graduates passed the Educational Commission for Foreign Medical Graduates exam compared with less than 25% for the Visa Qualifying Examination.
- 2) Imposes a two-year time limit on training programs with an optional third year if requested by the foreign medical graduate's home country. (Since this period is shorter than most approved residency programs, the attractiveness of American graduate medical education is greatly diminished.)

3) Eliminates the favored status of foreign medical graduates and the occupational preference entitling them to Immigrant Visas. Foreign medical graduates are now required to enter the United States on Exchange Visas which, unlike Immigrant Visas, cannot be converted to allow permanent residence.

Hospitals and medical schools can have the Visa Qualifying Examination requirement waived for individual training programs until December 31, 1980, if they demonstrate that a "substantial disruption in medical services" would otherwise occur.⁶

Not affected by the change in law are American graduates of foreign medical schools, since the immigration restrictions only affect the foreign-born.

IV. LOSS OF FOREIGN MEDICAL GRADUATES MOST SEVERE
IN NORTHEAST AND NEW YORK CITY

The 1976 law greatly reduces the pool of foreign medical graduates eligible for entry into the United States each year, cutting the annual supply of FMG's by two-thirds -- from 7,500 to 2,500 -- by 1980 or 1981, according to a 1978 forecast by the Department of Health and Human Services (formerly Health, Education and Welfare).⁷ Foreign medical graduates beginning four to five year long residency programs before December 31, 1980 will still be able to enter the country under the waiver provision. The full impact of the law, however, will not be felt until 1985, when the 1980 group will have graduated, and virtually all foreign medical graduates in the country will have entered under the stricter regulations.

The loss of FMG's will be most severely felt in the industrialized sections of the northeast and northcentral states, where hospitals have traditionally relied upon the foreign doctors.

New York City is and will continue to be particularly hard hit. The New York State Health Planning Commission predicts the number of foreign graduates in New York City will drop from 3,056 in 1978 to between 1,050 and 1,100 by 1984 as foreign medical graduates move on to new positions or return home and are not replaced. The City, with its large concentration of teaching hospitals, now trains one of every 12 physicians nationwide and relies upon these trainees to provide many essential services. Of the 8,103 doctors training in voluntary and municipal hospitals in New York City in 1978, 3,056 -- or 38% -- were foreign medical graduates.⁸

This high proportion of FMG's stems from the problem many City hospitals face when recruiting U.S. medical graduates. Elite Manhattan hospitals can easily attract interns and residents from top medical schools, but attempts to enroll these students for graduate training in aging and deficit-ridden, inner-city hospitals have been difficult in the past and are not getting any easier. Students are uncertain about the future of New York's troubled hospitals; 27 private hospitals have filed for bankruptcy since 1975, several municipal facilities are scheduled to be closed, and there is an overall shortage of nurses, equipment and medical supplies. Medical students also cite high crime rates and the deteriorated condition of inner-city neighborhoods where many municipal and small voluntary hospitals are located.

Thus, the reduction of foreign medical graduates in New York will have an uneven impact, barely affecting some hospitals, while crippling others. Although foreign medical graduates account for about 40% of the interns and residents citywide, the proportion in individual voluntary and municipal hospitals ranges from 7% to 100%. Foreign medical graduates amount to more than 50% of the housestaff -- interns and residents -- in 23 hospitals, and in 12 of these institutions, the proportion of foreign medical graduates is more than 75%.⁹ Eight hospitals with strong affiliations to medical schools have been able to reduce their use of foreign medical graduates since 1978, but many municipal and small voluntary hospitals serving poor patients remain heavily dependent on the foreign graduates.

TABLE I:

**DEPENDENCE ON FOREIGN MEDICAL GRADUATES IN NEW YORK CITY
BY HOSPITAL AND INCOME OF CATCHMENT AREA FAMILIES**

Hospital	Location	Catchment Area Families with in- come less than \$5,000 a year
		More than 75 Percent Foreign Medical Graduates
Bronx-Lebanon*	Bronx	30-40%
Cumberland	Brooklyn	25-30%
Goldwater	Manhattan	less than 20%
Greenpoint	Brooklyn	more than 40%
Brooklyn-Jewish*	Brooklyn	more than 40%
Jewish Memorial*	Brooklyn	30-40%
Kingsbrook*	Brooklyn	more than 40%
Methodist*	Brooklyn	20-30%
St. Johns Esp.*	Brooklyn	more than 40%
Sydenham	Manhattan	20-30%
Catholic Medical Center*	Brooklyn	NA**
Flushing*	Queens	NA**

51-75% Foreign Medical Graduates

Beekman*	Manhattan	more than 40%
Cabrini*	Manhattan	less than 20%
Coler	Manhattan	less than 20%
Coney Island	Brooklyn	25-30%
Elmhurst	Queens	NA**
Jamaica*	Queens	more than 40%
Veterans Administration	Bronx	NA**
Long Island College*	Brooklyn	25-30%
St. Vincent's*	Staten Island	20-30%
Lutheran*	Manhattan	30-40%
N.Y. Infirmary	Manhattan	less than 20%

30-50% Foreign Medical Graduates

St. Luke's*	Manhattan	30-40%
Beth Israel*	Manhattan	less than 20%
Booth*	Queens	NA**
Brookdale*	Brooklyn	30-40%
Kings County/Downstate	Brooklyn	30-40%
Harlem	Manhattan	20-30%
Staten Island*	Staten Island	20-30%
Metropolitan	Manhattan	more than 40%
Einstein*	Bronx	less than 20%
Long Island Jewish*	Queens	less than 20%
Maimonides*	Brooklyn	less than 20%

Less than 25% Foreign Medical Graduates

Bellavue	Manhattan	less than 20%
Bronx Municipal	Bronx	less than 20%
Lenox Hill*	Manhattan	less than 20%
St. Sinai*	Manhattan	more than 40%
Montefiore*	Manhattan	less than 20%
New York University*	Manhattan	less than 20%
St. Vincent's*	Manhattan	30-40%
New York Hospital*	Manhattan	less than 20%
Misericordia*	Bronx	less than 20%
N.Y. Eye and Ear*	Manhattan	less than 20%
Presbyterian*	Manhattan	30-40%
Roosevelt*	Manhattan	less than 20%

Source: "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals", New York State Health Planning Commission, 1979.

*Voluntary Hospitals
**NA = Not Available

V. SERVICE DELIVERY IMPLICATIONS BY BOROUGH AND SPECIALTY

The reduced pool of FMG's will cause the greatest problems in hospitals run by the New York City Health and Hospitals Corporation (HHC), which trains about 40% of the foreign graduates in the City.

Municipal health services in some boroughs will be more affected by the new immigration requirements than others. Brooklyn hospitals, with the oldest physical plants, are now the most reliant on foreign medical graduates, while certain Bronx hospitals with prestigious medical affiliations are the least dependent. North Central Bronx Hospital, for example, is a brand new institution affiliated with the renowned Montefiore Hospital. Bronx Municipal Hospital Center, despite its older facility, attracts American graduates through its affiliation with the Albert Einstein School of Medicine.

TABLE II:

SURVEY OF HEALTH AND HOSPITALS CORPORATION DEPENDENCE ON FOREIGN MEDICAL GRADUATES BY BOROUGH (1979)

<u>Borough</u>	<u>Total Number House Staff</u>	<u>Total Number FMG</u>	<u>Percent</u>
Brooklyn	937	547	58.4
Queens	470	171	36.4
Manhattan	1,023	321	31.4
Bronx	<u>784</u>	<u>245</u>	<u>31.3</u>
Total	3,214 =====	1,284 =====	39.9 =====

Source: Unpublished housestaff survey, Health and Hospitals Corporation, 1979.

While foreign medical graduates enter all medical specialties, they have tended to emphasize areas of less interest to American graduates. More than 80% of the foreign medical graduates, for example, are in four primary care specialties -- medicine, general surgery, pediatrics, and obstetrics/gynecology -- and four non-primary care fields -- pathology, psychiatry, anesthesiology, and rehabilitative medicine. Foreign graduates now make up 93% of the Health and Hospitals Corporation's pediatricians in Brooklyn, and the new policy could leave the borough without any children's services in the municipal hospitals.

The shortage of anesthesiologists throughout the City is already so severe that Dr. Joseph Gluffrida, Chief of Service at Manhattan's Metropolitan Hospital, warns that at Metropolitan "the Department of Anesthesiology wishes to go on public record that it cannot take responsibility for the lack of proper patient care."¹⁰

The extent of HHC's dependence on foreign graduates is detailed by borough and specialty in the following tables:

TABLE III:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION
ON FOREIGN MEDICAL GRADUATES BY
SPECIALTY AND BOROUGH (1979)

<u>Borough</u>	<u>Specialty</u>	<u># of House Staff</u>	<u># of FMG</u>	<u>Percent</u>
<u>Brooklyn</u>				
	Surgery	140	86	61.4
	Pediatrics	121	112	92.6
	Pathology	36	32	88.9
	Obs/Gyn	78	47	60.1
	Medicine	355	183	51.5
	Psychiatry	45	17	37.8
	Anesthesiology	16	14	87.5
<u>Manhattan</u>				
	Surgery	101	66	65.3
	Pediatrics	111	53	47.7
	Pathology	41	13	31.7
	Obs/Gyn	92	20	21.7
	Medicine	266	15	5.6
	Psychiatry	110	33	30.0
	Anesthesiology	49	33	67.3
	Rehab. Medicine	45	38	84.4
<u>Queens</u>				
	Surgery	34	8	23.5
	Pediatrics	62	24	38.7
	Pathology	21	20	95.2
	Obs/Gyn	21	3	14.2
	Medicine	146	28	19.2
	Psychiatry	72	36	50.0
	Anesthesiology	-	-	-
	Rehab. Medicine	17	14	82.3
<u>Bronx</u>				
	Surgery	69	18	26.0
	Pediatrics	112	25	22.3
	Pathology	17	6	35.3
	Obs/Gyn	49	22	44.8
	Medicine	203	58	28.5
	Psychiatry	66	14	21.2
	Anesthesiology	35	30	85.7
	Rehab. Medicine	18	16	88.8
	Specialty Totals	2,548	1,084	42.5

TABLE IV:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON
FOREIGN MEDICAL GRADUATES IN BRONX HOSPITALS (1979)

Hospital	Total %		%	Specialty	# House Staff	# FMG	%
	Staff	FMG					
Bronx Municipal	466	96	20.6	Surgery	41	0	0.0
				Pediatrics	54	3	5.6
				Pathology	13	4	30.8
				Obs/Gyn	24	3	12.5
				Medicine	89	2	2.2
				Psychiatry	47	2	4.3
				Anesthesiology	30	25	83.3
				Rehab. Medicine	13	11	84.6
Lincoln	176	135	76.7	Surgery	22	18	81.8
				Pediatrics	31	31	100.0
				Pathology	2	2	100.0
				Obs/Gyn	20	18	90.0
				Medicine	60	56	93.3
				Psychiatry	12	11	91.6
				Anesthesiology	-	-	-
				Rehab. Medicine	1	1	100.0
North Central	142	14	9.9	Surgery	6	0	0.0
				Pediatrics	27	1	3.7
				Pathology	2	0	0.0
				Obs/Gyn	5	1	20.0
				Medicine	54	0	0.0
				Psychiatry	7	1	14.3
				Anesthesiology	5	5	100.0
TOTALS	784	245	31.3	Rehab. Medicine	4	4	100.0

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TABLE V:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON
FOREIGN MEDICAL GRADUATES IN BROOKLYN HOSPITALS (1979)

Hospital	Total #		%	Specialty	# House Staff	# FMG	%
	Staff	FMG					
Cumberland	172	145	84.3	Surgery	34	28	82.4
				Pediatrics	32	28	87.5
				Pathology	11	9	81.8
				Obs/Gyn	22	17	77.2
				Medicine	70	63	90.0
				Psychiatry	NA	NA	-
				Anesthesiology	NA	NA	-
Greenpoint	144	119	82.6	Surgery	26	22	84.6
				Pediatrics	36	32	88.9
				Pathology	-	-	-
				Obs/Gyn	22	18	81.8
				Medicine	48	36	75.0
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
Kings County	338	221	41.1	Surgery	72	28	38.9
				Pediatrics	51	50	98.0
				Pathology	19	17	89.5
				Obs/Gyn	31	10	32.2
				Medicine	173	40	23.1
				Psychiatry	45	17	37.8
				Anesthesiology	16	14	87.5
Coney Island	83	62	74.7	Surgery	8	8	100.0
				Pediatrics	2	2	100.0
				Pathology	6	6	100.0
				Obs/Gyn	3	2	66.7
				Medicine	64	44	68.8
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
TOTALS	937	547	58.4				

TABLE VI:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON
FOREIGN MEDICAL GRADUATES IN QUEENS HOSPITALS (1979)

Hospital	Total #		%	Specialty	# House Staff	# FMG	%
	Staff	FMG					
Queens	338	82	24.8	Surgery	34	8	23.5
				Pediatrics	45	8	17.8
				Pathology	12	11	91.7
				Obs/Gyn	21	3	14.3
				Medicine	78	6	7.7
				Psychiatry	42	7	16.7
				Anesthesiology	-	-	-
				Rehab. Medicine	1	1	100.0
Elmhurst	140	89	63.6	Surgery	-	-	-
				Pediatrics	17	16	94.1
				Pathology	9	9	100.0
				Obs/Gyn	-	-	-
				Medicine	68	22	32.3
				Psychiatry	30	29	96.6
				Anesthesiology	-	-	-
				Rehab. Medicine	16	13	81.2
TOTALS	470	171	36.4				

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TABLE VII:

DEPENDENCE OF HEALTH AND HOSPITALS CORPORATION ON
FOREIGN MEDICAL GRADUATES IN MANHATTAN HOSPITALS (1979)

Hospital	Total #		%	Specialty	# House Staff	# FNG	%
	Staff	FNG					
Marion	261	122	46.7	Surgery	74	50	67.6
				Pediatrics	26	23	88.5
				Pathology	9	9	100.0
				Obs/Gyn	38	16	42.1
				Medicine	84	2	2.4
				Psychiatry	23	18	78.3
				Anesthesiology	1	1	100.0
Metropolitan	222	92	41.4	Surgery	27	16	59.3
				Pediatrics	23	15	65.2
				Pathology	-	-	-
				Obs/Gyn	17	3	17.6
				Medicine	65	7	10.8
				Psychiatry	30	13	43.3
				Anesthesiology	15	15	100.0
				Rehab. Medicine	5	5	100.0
Bird S. Coler	18	12	66.7	Surgery	-	-	-
				Pediatrics	2	2	100.0
				Pathology	-	-	-
				Obs/Gyn	-	-	-
				Medicine	6	2	33.3
				Psychiatry	-	-	-
				Anesthesiology	-	-	-
				Rehab. Medicine	6	6	100.0
Bellevue	517	95	18.4	Surgery	NA	NA	-
				Pediatrics	60	13	21.7
				Pathology	32	4	12.5
				Obs/Gyn	37	1	2.7
				Medicine	111	4	3.6
				Psychiatry	57	2	3.5
				Anesthesiology	33	17	51.5
				Rehab. Medicine	34	27	79.4
TOTALS	1,018	321	31.5				

In sum, if the Department of Health and Human Services prediction of a two-thirds reduction of foreign medical graduates nationally holds true for New York City, the Health and Hospitals Corporation will lose more than 800 physicians by 1984 -- one-half the HHC housestaff in pediatrics, child psychiatry, general surgery and obstetrics/gynecology. These losses will jeopardize the delivery of health services where the dependence on foreign medical graduates is most acute, especially at Cumberland, Greenpoint, Lincoln, Kings County, and Elmhurst hospitals.

Moreover, there is the strong possibility that HHC hospitals will lose more than the two-thirds reduction projected for the entire country. As the nationwide pool of foreign medical graduates shrinks, the competitive position of hospitals to recruit housestaff becomes more important. Financial problems and outdated facilities already put municipal hospitals at a disadvantage. Applications for internships and residencies at HHC hospitals dropped 8% between late 1977 and late 1978, and individual institutions heavily dependent on foreign medical graduates reported fall offs from 25% to 75%.¹¹ New York's difficulties in recruiting physicians only will be compounded by the immigration restrictions.

VI. HEALTH AND HOSPITALS CORPORATION MEDICAL PERSONNEL
COSTS INCREASE

The reduction of foreign medical graduates will force the Health and Hospitals Corporation -- in the short run at least -- to replace foreign graduates with more costly attending physicians and physician extenders (non-physician providers such as nurse practitioners, who perform medical tasks under the supervision of a doctor).

Replacing lost housestaff will be expensive for the Health and Hospitals Corporation. Interns and residents are a bargain for teaching hospitals. In exchange for training, they routinely work 70 to 90 hours a week and are paid less than half the salary of an attending physician.

Replacement costs will rise each year from 1980 to 1985, as increasing numbers of foreign medical graduates are affected by the new law and the expiration of the waiver provision. In 1981, only first year housestaff will be affected by the restrictions; upper level positions will continue to be occupied by foreign medical graduates already in the United States. By 1985, all levels of housestaff will be affected, and the foreign medical graduate pool will have been greatly reduced.

If the FMG reduction begins to disrupt hospital training programs, upper-level interns and residents may decide to move to more stable institutions. This would further undermine the viability of entire departments, jeopardizing still more health services.

Analysis by the Council President's Office indicates that in the four primary care specialties alone -- pediatrics, obstetrics/gynecology, medicine and surgery -- replacement costs for foreign medical graduates in Health and Hospitals Corporation hospitals will be at least \$4.4 million in 1981. All cost estimates in this report assume that 75% of the foreign medical graduates now filling the 204 entry level positions are replaced by physician extenders and attending physicians, and that HHC will actually be able to find replacement personnel.

In 1982, when first and second year housestaff are affected, costs will rise proportionately, because more attending physicians will be needed to compensate for the greater responsibilities of second year interns and residents. Total replacement costs for the primary fields: \$9.9 million.

Primary care replacement will continue to escalate in succeeding years, reaching \$15.4 million in 1983 and \$21 million in 1984.*

All these figures are conservative and none take into account the additional expense of replacing the non-primary care specialists, nor doctors in voluntary hospitals. Since it was not clear how many personnel will have to be replaced in the non-primary care fields, the added costs of hiring housestaff in pathology, rehabilitative medicine, anesthesiology and psychiatry were not included in this report.

*For an explanation of the cost methodology see Appendix

Nor do these estimates reflect added costs to state mental health hospitals which are also heavily dependent on foreign medical graduates. In the five state institutions based in New York City, nearly all psychiatric residents are FMG's. The Director of Medical Education at Kingsboro Psychiatric Center reports a severe recruitment problem already and predicts that "patient care will suffer in the future because we will not have enough physicians."

VII. RECOMMENDATIONSA. Short Term Recommendation

Although the new FMG policy is certain to drive up expenses in City hospitals, several steps should be taken to minimize the additional costs.

In the short run, Congress must extend the phase-
in period of the law from December 31, 1980 to December 31, 1985,
allowing the federal government to continue granting waivers to avoid a "substantial disruption of health services."

The present waiver provision went into effect in 1978. Between 1978 and today, New York City has increasingly relied on waivers to fill housestaff positions in primary care, according to Magdalene Miranda, Chief of the International Education Program, Health Resources Administration, which administers the waiver program.

<u>Waivers Approved</u>		
<u>Year</u>	<u>National Totals</u>	<u>New York City Only</u>
1978	18	9
1979	110	81
Jan. 1980	17	17
Feb. 1980	96 pending	95 pending

Extension of the waiver deadline would give the Health and Hospitals Corporation and many affected voluntary hospitals more time to prepare for the reduction of available foreign medical graduates. It must be pointed out that L. C. H. recently, the hospital community in New York City -- including the Corporation -- had not used the time already allowed by the federal government to seek replacements for foreign graduates. As a result, Henry Foley of the federal Health Resources Administration expressed "concern that alternatives for meeting the future needs of the educational/service programs have not been adequately addressed" by the Corporation.¹²

Representatives of the Council President's Office, the Corporation and Chiefs of Service of the affected municipal hospitals have subsequently met with Dr. Foley to respond to his comments. The Corporation has made a commitment to present a working plan for seeking competent medical personnel to fill vacancies left by the shrinking pool of qualified foreign medical graduates. It is generally agreed that a suitable plan must be a part of, or a predicate to, the waiver application of any hospital, public or voluntary, if the waiver period is extended.

B. Long Term Recommendations

Extension of the waiver exemption until 1985 will, in and of itself, do nothing to solve the underlying problems created by the reduced availability of foreign medical graduates. Long term solutions must be found and implemented to insure the continued provision of essential medical services, particularly in the primary care specialties:

1. Coordinate length of foreign medical graduate's stay in United States with length of training program. The law as presently written imposes a two-year time limit on training (with an optional third year if requested by the foreign medical graduate's home country). After that, the physician must leave the United States, even if the training program has not been completed. Since this period is shorter than most approved residency programs, the attractiveness of American graduate medical education is greatly diminished.

Alien physicians who come to the United States for graduate medical education and who otherwise qualify for entry should be allowed to remain for a period equal to the length of their program. This would permit foreign medical graduates to return home with the appropriate skills. Medical care would not be compromised by shortages of upper-level resident physicians, created by the forced departure of foreign medical graduates after two years.

2. Include municipal and voluntary hospital training programs in National Health Service Corps service commitment. The National Health Service Corps program provides scholarships to medical students in return for a service commitment in medically-underserved areas. But current law bars these physicians from counting any portion of their training as interns or residents towards fulfillment of their service obligation, and also precludes any Corps service in municipal hospitals.

The law should be amended to allow participation in designated training programs in voluntary and municipal hospitals to fulfill the physician's service obligation. Programs should be designated only: (1) if they involve primary care specialties in medically underserved areas such as Brooklyn and (2) are in hospitals currently dependent on foreign medical graduates for the provision of care.

There are several advantages to this approach. First, the National Health Service Corps physicians would provide essential services to medically underserved communities while continuing their medical education. Since many physicians end up practicing medicine in the community where they are trained, this amendment will help retain doctors in underserved areas. Second, it would reduce the direct cost of the program to the Federal government since the trainees would be paid by the teaching hospital rather than Washington, D.C.

3. Intensify recruitment of United States medical graduates. In 1978, 1,132 of the more than 14,000 graduates of U.S. medical schools were from schools located in New York City. More than half the local graduates stayed in the City for their postgraduate training, but only 30 percent of these entered the municipal system.

Recruiting more United States medical graduates to fill housestaff positions formerly held by foreign medical graduates will not be easy. Attracting graduates means reversing the competitive disadvantage of HHC hospitals. The uncertainties created by municipal hospital closings, and well-publicized shortages of nurses, medical supplies and equipment make this unlikely for most HHC hospitals. The best opportunity is in Brooklyn, where the foreign medical graduate problem is the greatest.

A successful July 1981 opening of Woodhull Hospital in Brooklyn, coupled with the closing of aging and substandard Greenpoint and Cumberland Hospitals and a 170-bed reduction at overcrowded Kings County Hospital, should greatly improve the attractiveness of the Brooklyn housestaff training programs. Woodhull's new physical plant and its direct affiliation with Downstate Medical School hopefully will lead many more highly qualified applicants to apply for housestaff positions, despite Woodhull's obvious planning and design flaws in this age of austerity.

Opening a 640 bed hospital successfully is a complex process and depends on many interrelated actions taking place in concert. Without proper preparation, Woodhull is likely to open late or haphazardly, greatly diminishing its potential to recruit. To take full advantage of the recruiting opportunity presented by Woodhull, the Corporation must implement the innovative medical programs now planned for the facility.

4. Step-up recruitment of American-born foreign medical graduates. Enrollment in foreign medical schools has become increasingly attractive for Americans who want to study medicine and cannot get into U.S. schools. The American Association of Medical Colleges conservatively estimates there are 6,000 such students studying throughout the world.¹³ Recruiting more U.S. graduates of foreign medical schools offers real potential for replacing foreign-born FMG's.

At present, about 7 percent of HHC housestaff positions are filled with American graduates of foreign medical schools.¹⁴ Since many U.S. foreign medical graduates are from the New York metropolitan area, local hospitals can offer not only graduate education but also the opportunity to be near families and friends after many years away.

To enlist more of these students, the Corporation should develop outreach programs to attract the most qualified. "Fifth Pathway" programs must also be expanded. These programs were developed because several foreign medical schools -- particularly those in Mexico -- require an additional year or more of clinical training after completion of formal course work, but before the awarding of a medical degree. Students considered this unreasonable since the training was often conducted with little or no supervision. The "Fifth Pathway" permits a year of clinical training, under the supervision of an American medical school, to replace the required training in Mexico and other countries. Successful completion of this year allows entry into graduate training programs, without the necessity of certification by the Educational Commission for Foreign Medical Graduates or actual possession of the medical degree.

5. Reduce surplus housestaff positions. Some foreign medical graduates are filling positions in specialties that exist more for teaching purposes than for patient needs. Likewise, some specialty services now offered in a number of municipal and voluntary hospitals could be consolidated and regionalized, allowing a more efficient use of a reduced number of physicians.

The Corporation should undertake a program-by-program analysis to identify housestaff positions that can be eliminated without adversely affecting the delivery of services to reduce the number of graduate physicians needed.

In reality, any strategy to reduce dependence on foreign physicians must employ a combination of these options in order to succeed. For too long, HHC has not had to compete for quality personnel because of the ready availability of FMG's. That time has passed. A plan -- with firm targets for implementation -- must now be devised to replace these physicians, especially in the primary care specialties.

VIII. CONCLUSION

The previous pages document the critical doctor shortage New York City must confront over the next few years, particularly in municipal and voluntary hospitals in inner-city neighborhoods. This report makes specific short and long range recommendations to help the City cope with what could be a serious health care delivery crisis.

But lost in this debate is the larger issue of maldistribution -- by specialty and geography -- of physicians trained here in the United States.

With educational priorities in American medical schools stressing diagnosis and treatment of exotic illnesses over day-to-day delivery of basic medical services, it is not surprising that many medical students opt for such over-subscribed specialties as neurosurgery and tropical medicine, rather than such badly needed primary care fields as family practice and pediatrics.

And, lured by the financial rewards offered by affluent urban areas and suburbs, not enough physicians elect to serve in the inner-city. In most areas of the Bronx, for example, one doctor is available for every 10,000 people, as contrasted with a statewide ratio of one doctor for every 405 people. Residents of poor neighborhoods depend on hospital outpatient and emergency room service for primary care. As the Chief of Pediatrics at Greenpoint Hospital put it: "Interns and residents are the family doctors of the poor." And in many municipal hospitals today, that intern or resident is likely to be foreign-born.

One might say that the fact there is a need for this study and its recommendations is a sad commentary on the American medical profession today. For stop-gap legislation regarding the FMG cutoff is not the answer. Redistributing medical personnel, so that all specialties and regions are sufficiently covered and access to health care is assured for the poor and working class, depends on reordering the priorities of American medical education. It rests with health policy-makers, both public and private, and physicians themselves to develop a coherent medical manpower policy to accomplish these goals.

APPENDIXCOST METHODOLOGY FOR REPLACING FOREIGN MEDICAL GRADUATE
HOUSESTAFF WITH ATTENDING PHYSICIANS AND PHYSICIAN EXTENDERS

A number of assumptions were used to estimate the replacement costs should unfilled housestaff positions result from the full implementation of P.L. 94-84. These assumptions were made conservatively due to the inherent uncertainty of forecasting the Corporation's ability to recruit from the reduced pool of FMG's, as well as the wide variation in individual training programs at HHC hospitals. Since the delivery of necessary health services -- not lost educational opportunities -- are the major concern, only the costs of replacing direct patient care activities were considered.

Data as to the number of foreign medical graduates in entry and intermediate level housestaff positions were obtained from the 1978 Health and Hospitals Corporation Housestaff Survey and Findings, since the 1979 survey was not categorized by year of training. No significant changes in personnel, however, have occurred between 1978 and 1979.

In 1978, FMG's occupied 132 of the 277 entry level positions in the non-primary care specialties (pathology, anesthesiology, psychiatry, and rehabilitative medicine) and 480 of the 1,064 positions at all levels. No replacement costs were calculated for these specialties since a large portion of physician time is spent on education-related activities, not patient care. (It is clear, however, for the same reasons outlined below, that replacement costs for patient care activities performed by these specialists will be higher.)

In the primary care specialties (pediatrics, obstetrics/gynecology, medicine and surgery), foreign medical graduates occupied 204 of the 536 entry level positions and 642 of the 1,551 positions at all levels. Replacement costs were calculated for these specialties only -- because most physician time is spent on direct patient care.

A. Assumptions and Methodology

1. Entry level housestaff (PGY-I) work an average of 80 hours per week. Ten percent of this time was discounted as educational so that direct services were considered to be provided 72 hours per week.

2. Intermediate level housestaff (PGY-II and III) work an average of 72 hours per week. Ten percent of this time was discounted as educational so that direct services were considered to be provided 65 hours per week.

3. It was assumed that all service hours are necessary for patient care.

4. Replacement providers (physician extenders and attending physicians) work a standard 40-hour week.

5. Entry level housestaff (PGY-I) could be replaced on a one-to-one basis by physician extenders. Supervision by attending physicians, equal to one attending for every ten physician extenders, would be necessary to assure adequate quality of care.

6. Intermediate level housestaff (PGY-II and III) could be replaced by 0.5 physician extender and 0.5 attending physician. (This probably understates physicians duties, underestimating additional costs.)

7. Physician extenders were considered to be salaried at \$25,000 a year (\$20,000 plus 25 percent fringe benefits). Attending physicians were considered to be salaried at \$50,000 a year (\$40,000 plus 25 percent fringe benefits). Housestaff were considered to be salaried at \$25,000 a year (\$20,000 plus 25% fringe benefits). While current starting salaries for housestaff and physician extenders are in fact lower than those cited above, these averages include adjustments for seniority and inflation over the next three years.

B. Individual Housestaff Replacement Costs

1. For each unfilled first-year housestaff position, the additional replacement cost is \$29,000

1.80 physician extenders X \$25,000 = \$45,000

.18 attending physicians X \$50,000 = \$ 9,000

\$54,000

(\$54,000 - \$25,000 unpaid housestaff salary = \$29,000)

2. For each unfilled intermediate level (PGY-II and III) housestaff position, the additional replacement cost is \$35,900

0.812 physician extenders X \$25,000 = \$20,300

0.812 attending physicians X \$50,000 = \$40,600

\$60,900

(\$60,900-\$25,000 unpaid housestaff salary = \$35,900)

C. Estimated Additional Costs-By Year

1981

In 1981, only first year housestaff will be affected by the elimination of the waiver since upper level positions are filled with foreign medical graduates already admitted to the United States under the old restrictions. Assuming 75 percent of the 204 entry level positions will have to be replaced by physician extenders and supervising attending physicians, the additional cost will be \$4.4 million.

153 first year positions X \$29,000 replacement
cost per position = \$4.4 million

1982

In 1982, both first and second year housestaff will be affected by the elimination of the waiver. Third year housestaff positions will still be filled with foreign medical graduates admitted to the United States under the old restrictions. Assuming all first year housestaff are promoted and assuming 75% of the first and second year positions will have to be replaced, the additional cost will be \$9.9 million.

153 first year positions X \$29,000 replacement
cost per position = \$4.4 million

153 second year position X \$35,900 replacement
cost per position = \$5.5 million

1983

In 1983, first, second and third year housestaff will be affected by the elimination of the waiver. Assuming all first and second year housestaff are promoted, and assuming that only 75% of the third year positions will have to be replaced, the additional cost will be \$15.4 million.

153 first year positions	X \$29,000 replacement	
cost per position	=	\$4.4 million

153 second year positions	X \$35,900 replacement	
cost per position	=	\$5.5 million

153 third year positions	X \$35,900 replacement	
cost per position	=	\$5.5 million

1984

In 1984, first, second, third and fourth year housestaff will be affected by elimination of the waiver. All housestaff are promoted, and assuming only 75% of the fourth year portions will have to be replaced, the actual cost will be \$21 million in 1984.

153 first year positions	X \$35,900 replacement	
cost per position	=	\$4.4 million

153 second year positions	X \$35,900 replacement	
cost per position	=	\$5.5 million

153 third year positions	X \$35,900 replacement	
cost per position	=	\$5.5 million

153 fourth year positions	X \$35,900 replacement	
cost per position	=	\$5.5 million

FOOTNOTES

1. Update Report on Foreign Medical Graduates in the United States, Department of Health, Education, and Welfare, 1977, Table IV.
2. "Annual Report on Medical Education in the United States, 1977-1978", Journal of American Medical Association, 240: 2837-2846 (1978).
3. "Foreign Medical Graduates and the Issue of Substantial Disruption of Medical Services", New England Journal of Medicine, 299: 745-751 (1978).
4. "Foreign Medical Graduates in Graduate Medical Education Programs in New York City Hospitals", New York State Health Planning Commission (1979).
5. Title VI, P.L. 94-484, October 12, 1976, 90 Stat. 2243, as amended by P.L. 95-83, August 1, 1977, 91 Stat. 383.
6. Ibid.
7. New York State Health Planning Commission, op. cit.
8. Ibid.
9. Ibid.
10. July 24, 1979 memorandum from Dr. Joseph E. Guiffrida to Dr. Camille Mallouh, President, Medical Board, Metropolitan Hospital.
11. New York State Health Planning Commission, op. cit.
12. July, 1979 letter from Henry Foley, Ph.D., Administrator, Health Resources Administration, to Mr. Jack Koretsky, Executive Vice President, Health and Hospitals Corporation

13. "Career Choice and Performance on State Licensing Examinations of 'Fifth Pathway' Students", New England Journal of Medicine, 299: 227-250 (1978).
14. Health and Hospitals Corporation Housestaff Study and Findings, published May, 1978.



COLLEGE OF MEDICINE AND DENTISTRY OF NEW JERSEY

NEW JERSEY MEDICAL SCHOOL

100 Bergen Street
Newark, New Jersey 07103

May 21, 1980

Peter W. Rodino, Jr., Chairman
Committee on the Judiciary
Congress of the United States
House of Representatives
Washington, D.C. 20515

Dear Congressman Rodino:

Thank you for your letter of 12 May, 1980, regarding the hearings on H.R. 7118.

While I am not familiar with the details of the bill, I assume that it is an attempt to postpone the date for termination of the "substantial disruption" waiver related to Public Laws 94-484 and 95-83.

I wish to make it known that pediatric residency training programs such as ours at the New Jersey Medical School, which provides a vast amount of service to the indigent children of Newark, Elizabeth, and Paterson, have not found it possible to make a rapid transition from reliance on foreign medical graduates to alternative methods of health care delivery. We have been making a determined effort to recruit nurse practitioners, full-time pediatricians, and increased numbers of graduates of American medical schools to replace foreign graduates, but the task is a slow and tedious one fraught with many obstacles, not the least of which is the considerable increase in the cost of hiring alternative professionals.

It is clear to me that it will take at least three additional years (beyond the December 1980 date which currently exists) for us to be able to make a reasonable transition without causing a drastic reduction in medical services to indigent children in our area.

I would be happy to expand on this brief outline of the need for an extension of time at any future hearing of your committee or in a more detailed written communication if you so desire.

Sincerely yours,

Franklin C. Behrle, M.D.
Professor and Chairman
Department of Pediatrics

FILE COPY

THE NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

PROPOSAL FOR REDUCING RELIANCE ON FOREIGN MEDICAL GRADUATES

Submitted to the members of the
House Subcommittee on Immigration,
Refugees, and International Law

May 14, 1980

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SUMMARY

As the principal provider of health care to New York City's poor, near-poor and inner-city residents, the Health and Hospitals Corporation and its seventeen public hospitals are heavily dependent upon the physician services of foreign medical graduates (FMGs).

More than one-quarter of the nation's FMGs train in New York City which has been unable to attract enough American medical graduates to fill house staff positions.

Because of the reluctance of American trained physicians to serve in poor and medically underserved neighborhoods, approximately forty-three percent or 1,700 out of 4,000 house officers in HHC facilities are FMGs and the departments of several of our hospitals are totally dependent on FMGs.

HHC is developing a strategy for reducing its reliance on FMGs but the success of this strategy is threatened by existing provisions of the Health Professions Educational Assistance Act of 1976. This act drastically reduces the granting of visas to FMGs seeking entry to the United States. Its effect has been cushioned, so far, by the granting of waivers to hospitals demonstrating that the loss of FMGs would disrupt their services. However, this grace period runs out on December 31, 1980 and the number of entering FMGs will decline steadily from 3,057 to 1,100 by 1984.

HHC's strategy, as described in the accompanying report, requires time for implementation. A sudden interruption of FMG availability

would impact severely on HHC hospitals and voluntary hospitals serving similar inner-city populations.

Therefore, we urge the Congress to enact amendments to the Act which will achieve the following results:

- Extend until December 31, 1985 the period during which hospitals may seek waivers from existing entry qualifications for FMGs.
- Allow FMGs entering the county under the new restrictions to stay long enough to complete their training program (usually four to five years). The law now imposes a two-year limit.
- Permit the use of National Health Service Corps doctors in urban municipal hospitals, either as interns or residents or as medical staff.

The following report details the historical and legislative perspective and the principal elements of the Health and Hospitals Corporation strategy to reduce its reliance on foreign medical graduates.

The New York City Health and Hospitals Corporation ("HHC") operates seventeen hospitals and numerous clinics for the City of New York. It also operates the Emergency Medical Service which responds to more than 600,000 calls for ambulance service annually. HHC hospitals have a total bed complement of nearly eleven thousand and provide over three million inpatient days of care and some six million emergency room and clinic visits per year.

HHC facilities serve the poor and near-poor, many of whom would not be treated elsewhere. Most of these facilities are located in medically under-served areas of the City and HHC facilities are often referred to as "family doctors for the poor." Because of their inner-city location and attendant social conditions a number of HHC hospitals have found it difficult to recruit graduates of United States medical schools.

As a result, despite the desire of all HHC hospitals to fill house staff positions with American medical graduates, approximately forty-three percent of all house officers in HHC facilities are foreign medical graduates ("FMGs") and departments of several hospitals are totally dependent on FMGs.

The New York City Health and Hospitals Corporation, believing its FMG dependence, and its problems in seeking alternate sources of medical personnel, to be representative of several areas of New York State and several adjoining states as well, urges

Congress to ameliorate the restrictions on FMGs contained in the Health Professions Educational Assistance Act of 1976, and to assist FMG-dependent hospitals in recruiting physicians from other sources.

LEGISLATIVE HISTORY

The Health Professions Educational Assistance Act of 1976 ("Act") (P.L. 94-484 as amended by P.L. 95-83) significantly altered the provisions of the Immigration and Nationality Act applicable to foreign medical graduates who enter the United States as either permanent immigrants (I Visa holders) or as temporary visitors (J Visa holders). Congress, believing that United States medical schools were producing enough graduates to fill all internships offered in American hospitals, held that the practice of medicine was no longer considered a "shortage occupation." The changes were therefore designed to restrict the entry of FMGs into this country.

Specifically, the law:

- 1) raised the educational requirements for entry by substituting the Visa Qualifying Examination for the ECFMG examination. (The present VQE pass rate of twenty-five percent and the long lead time required for application have greatly diminished the pool of qualified FMGs);

- 2) imposed a limit of two years of training in the United States on alien physicians. This period is shorter than virtually all approved residencies thereby greatly diminishing the attractiveness of American graduate medical education to FMGs. Prior to this change, FMGs could remain in the country for the duration of their training period;
- 3) prevented FMGs from obtaining I Visas based on educational preference; accordingly, FMGs must enter this country either on a J Visa, which is not convertible to an I Visa, or follow normal immigration procedures based on quotas for individual countries. The ability of foreign medical graduates to immigrate was thereby greatly curtailed;
- 4) permitted specific programs within hospitals to seek waivers from the testing requirement imposed in paragraph one above, provided that the number of FMGs in the program was gradually reduced. The allowed time for obtaining such waivers expires on the last day of 1980.

The restrictions imposed by the 1976 Act have already had a substantial impact on the flow of FMGs into the United States. The Department of Health, Education and Welfare estimated in

1979 that approximately 2,500 alien physicians enter the country under the new provisions of the Act, compared to previous totals of 7,500 physicians per year.

HEALTH & HOSPITALS CORPORATION'S RELIANCE ON FOREIGN MEDICAL GRADUATES

In academic year 1977-78 the Health and Hospitals Corporation and its affiliated voluntary institutions employed 3,992 house officers; FMGs represented 43 percent of that work force (1,701 of 3,992 individuals).

A follow-up survey conducted in November 1979 revealed that both the percentage and distribution of foreign medical graduates were essentially unchanged, notwithstanding the advent of the Act.

Foreign medical graduates are unequally distributed through the municipal system on an institutional basis (Table 1).

The percentage of FMGs in each institution is related to both the strength of the affiliation institution and the physical condition and location of the hospital. Direct medical school or major voluntary affiliates have the most success in recruiting USMGs. Weak voluntary affiliates have the least success.

FMGs are also unequally distributed through the various hospital departments (Table 2). For example, Anesthesiology and Pathology have very high percentages of FMGs in their training programs; however, the majority of alien physicians are in the primary care areas (Medicine, Pediatrics, OBS/GYN and Surgery) which provide direct patient care. Any discontinuance in the availability

of these primary care physicians without adequate replacement will create a substantial health care emergency in New York City. The table below shows the number and percentage of alien physicians in these major service areas in HHC hospitals:

<u>Department</u>	<u>% FMGs</u>	<u>Number of FMGs</u>
Pediatrics	62	322
Surgery	49	287
Medicine	25	246
OB/GYN	41	112

These four departments account for over 50% of the alien physicians and are responsible for the majority of direct care delivered in HHC institutions.

Health and Hospitals Corporation hospitals have already experienced a sharp decrease in the number of applications received from FMGs for house staff training positions for the 1980-81 academic year. A questionnaire survey of HHC facilities and affiliated institutions revealed that the number of applications received by December 15, 1978 was eight percent less than had been received by the same date previously. The drop in applications was not uniform but rather was concentrated at the institutions most dependent on aliens for the provision of medical care. A follow-up survey is currently in progress which indicates that the decline in applications for this

academic year is even more pronounced than in the previous year. Heads of the involved clinical departments have attributed this decline to a number of factors including:

- 1) confusion about the provisions of the revised immigration laws,
- 2) the time limitation of three years of training in the United States for FMGs.

Since a reduction in the number of FMGs applying for house staff positions has not in and of itself increased the desire of graduates of U. S. medical schools (USMGs) to apply for programs in NHC institutions, it has been necessary to obtain waivers and, where possible, to hire any available personnel with appropriate medical credentials who are willing to work in a municipal hospital setting. The number of such persons is limited and this hiring resource may already have been exhausted.

Finally, it should be noted that FMG dependence has not been confined to municipal hospitals in New York City. Many voluntary hospitals, particularly those which serve similar populations as municipal facilities have serious recruitment problems which have been aggravated by passage of the Act; requests for waivers by voluntary hospitals confirm this assertion.

Serious FMG dependence is not limited to New York City and or indeed to New York State. The study undertaken by

the AMA in 1977 shows substantial state-wide FMG dependence in a number of states (Table 3). It is safe to assume that if the distribution of FMGs was wide-spread in 1977, it probably remains so today.

COMMITMENTS TO CHANGES IN RECRUITING PROGRAMS

The New York City Health and Hospitals Corporation fully supports the apparent goal of existing Federal legislation governing entry of FMGs--i.e., filling all physician training positions in American hospitals with United States medical graduates.

The intent of the legislative changes offered at the beginning of this paper is not to alter this goal, but to allow hospitals which rely heavily on FMGs to devise alternative recruiting strategies. Commencing such strategies properly and, more important, determining if they will generate enough doctors requires time. It is urged here that until it has been proven that USMGs are available and willing to serve in all hospitals, the use of legally qualified FMGs should be extended.

In whatever time is allowed for the temporary continued use of FMGs, the Health and Hospitals Corporation is determined to take the following steps:

- 1) increase recruitment of United States medical graduates;
- 2) increase recruitment of qualified United States

- foreign medical graduates ("USFMGs");
- 3) recruit VQE qualified foreign medical graduates;
- 4) provide care with attending physicians and/or physician extenders ("PEs");
- 5) review programs to determine the feasibility of adjusting such programs to diminished staffing capacity.

1) Increased Recruitment of United States Medical Graduates

In 1978, 14,395 students graduated from medical schools in the United States; eight percent of these graduates attended medical school in New York City. Retention of a greater number of these graduates is crucial if reliance on FMGs is to be decreased.

The majority of USMGs who enter the municipal system are attracted to the major teaching hospitals that are closely allied with a medical school or a prestigious voluntary teaching hospital. The results of the National Interns and Residents Matching Program ("Match") vary from one HHC institution to another. A 1979 survey conducted by HHC showed that certain hospitals offer and fill 100 percent of their openings through the Match; others request matches for only some positions and receive none. Over all, 42 percent of all HHC entry level positions were filled by the Match, and 65 percent of all positions offered by HHC in the Match were filled. This survey

also demonstrated that municipal hospitals with strong affiliates can recruit through the Match, but very few USMGs choose to train at the smaller, less well-known Corporation hospitals. Therefore, training must be made more attractive through a variety of different means. Specific actions planned include:

- A) Since strong affiliations have proven to be an effective means of attracting USMGs, efforts will be made to strengthen affiliations where possible. For example, the Corporation is committed to closing two of its older institutions, Cumberland and Greenpoint Hospitals, and replacing them with the new Woodhull Hospital. Woodhull will be a direct teaching hospital of Downstate Medical School which is a division of the State University of New York (SUNY). This should have a positive effect on recruitment since the strong SUNY affiliation and ultra-modern facility will be positive recruitment factors when compared with the previous weaker voluntary affiliates and ancient physical plants at the hospitals to be closed.
- B) The Health and Hospitals Corporation will continue efforts to totally integrate all currently free-standing training programs operated in its facilities

with those operated by affiliates. This strategy is specifically applicable to subspecialty training programs. In primary care programs such as medicine and pediatrics, the need for continuity of care may dictate against routine rotation of all house staff through several institutions. Integration of training programs with those of strong affiliates has a number of benefits. The recruitment efforts are strengthened, the programs benefit from the expertise provided by the expanded number of attending physicians and the number of individuals required in a single combined program is often less than in a number of free-standing programs.

- C) The Corporation will request that the State University of New York and the New York State Legislature require medical students at state supported institutions to enter into a payback agreement for a portion of the state subsidy that they have received towards their education. The Corporation proposes that students entering school be required to agree to pay back a portion of the subsidy or practice or train in medically underserved areas of New York State for three years.

Since many physicians make their career choices about

practice location during training, this is an opportunity to encourage many young physicians to remain in the municipal system.

- D) HHC will request that the State of New York assign a number of the medical students who will graduate from both the University of Vermont and the Sackler School of Medicine in Israel under New York State scholarship sponsorship to the municipal system. These individuals owe the State of New York a number of years of service in underserved areas in exchange for their education. The Corporation will request 25 of these individuals in the next academic year.
- E) Recruitment of National Health Service Corps physicians into the municipal system. This policy would require changes in the Federal Law governing Corps members since they are currently barred from counting periods of training as fulfillment of their service obligation. A change in these rules would enable American-trained physicians to work in designated hospitals located in Health Manpower Shortage Areas and fulfill their obligation to the Federal government. The programs would be primary care type residencies that Corps members could choose in lieu of other assignments.

2) Recruitment of United States Foreign Medical Graduates (USFMGs)

The American Association of Medical Colleges estimates that approximately 6,000 Americans are currently attending medical school outside of this country. The majority of USFMGs are natives of the Northeastern portion of the U.S.; over 40 percent enter training programs in New York State. In 1978, 6.4 percent of the house officers in programs affiliated with the New York City Health and Hospitals Corporation were USFMGs (251 of 3,992).

The Health and Hospitals Corporation will actively seek to hire a greater number of qualified USFMGs to replace alien physicians. A variety of means will be employed to attract qualified students including:

- A) Expansion of elective offerings and externships for qualified USFMGs. Students participating in these programs receive exposure to the municipal institutions and often apply for post-graduate positions in these hospitals. The cost of such efforts are small and afford the opportunity to recruit and evaluate students.
- B) A request by HHC to the State University of New York to waive the \$4,500 tuition for Fifth Pathway students in exchange for a pledge to accept house officer training in designated

areas. A recent report in the New England Journal of Medicine indicated that the majority of both New York State residents and non-residents in New York Fifth Pathway programs remained in the State for training after completion of those programs. Expansion of the Fifth Pathway combined with tuition forgiveness plans could provide additional physicians for shortage areas. A number of voluntary institutions are currently waiving the tuition in exchange for a promise to train in the institution once the training year is completed. Since many of the Fifth Pathway programs are affiliated with SUNY Downstate, the State of New York's approval is necessary for this to be effective in the municipal system.

3) Recruitment of VQE Qualified Foreign Medical Graduates

Recruitment of foreign medical graduates is possible under the provisions of P.L. 94-484; the potential number of alien physicians who will be available in the future is subject to much debate. The Department of Health, Education and Welfare estimates that approximately 2,500 FMGs will enter the U. S. annually after expiration of the waiver provision, while a study conducted by the New England Journal of Medicine projects reduction of from 33 to 60 percent from the 1975 total of 8,000 entrants.

The New York City Health and Hospitals Corporation has accepted the HEW projection of 2,500 entrants for its planning purposes. It is estimated that approximately one hundred fifty entry level FMGs will be recruited from the available pool representing six percent of the total, a reduction of 64 percent from the 400 FMGs in HHC entry level positions currently. However, this estimate may be exaggerated since most FMGs in the municipal system have entered on I Visas and many have used the family preference procedures in the past. FMGs who enter would be highly qualified and available for both education and training. VQE qualified applicants would be directed to the primary care specialties where their services are most acutely needed rather than the more esoteric clinical subspecialties.

4) Use of Attending Physicians and/or Physician Extenders

The complete replacement of FMGs with either attending physicians and/or physician extenders is neither financially feasible nor practical, but HHC is prepared to use such personnel when and if FMGs in vital primary care programs cannot be replaced from other sources.

Economically, replacement of even small numbers of house officers is extremely expensive. The reasons are as follows:

- A) House officers generally work between 65 and 80 hours per week. Three or four salaried professionals would be required to replace

two house officers.

- B) Replacement personnel (either MDs or PEs) are less willing to work many of the night and weekend hours required.
- C) House officers are paid approximately the same salary as physician extenders and less than one-half what an attending physician receives. The compensation formula of house staff does not allow for overtime; other employees are entitled to this benefit.
- D) Physician extenders are not physicians and therefore are inappropriate for many of the duties of house officers; e.g., coverage of I.C.U.s at night. By law, physician extenders must be supervised by an attending physician when they work.

Because of the above factors, the average incremental cost of replacing a house officer with salaried staff is approximately \$34,000. Therefore, replacement of only 30 FMGs with either attendings or physician extenders would cost one million dollars. There are 1,700 FMGs in the system currently.

Replacement has taken place in a number of significant areas. For example, the Department of Pediatrics at Kings County Hospital currently employs five physician extenders and is

looking for additional individuals. The Department of Pathology at Downstate Medical Center has begun an innovative Pathology assistant program to enable them to lessen both their own dependence on aliens and provide individuals for other hospitals. The Corporation is also heavily utilizing nurse anesthetists to replace Anesthesia residents where possible. Numerous efforts are underway -- the major hindrance is the cost. However, where necessary, both physician extenders and attending physicians will be hired to replace FMGs to prevent service interruptions.

5) Reduction of Training Programs

The Corporation is committed to assessing its need for existing training programs and to reduce or phase them out if they prove to be either unnecessary or impossible to maintain because of the changed immigration laws. The Corporation has already examined a number of programs in the past and made reductions in positions. For example, in 1978 a number of Pathology programs agreed to a voluntary reduction in size over a four year period. The net result will be a reduction of 20 positions representing 18% of all available training program positions in Pathology. In addition, the Surgery program in one HHC hospital was reduced by fifteen positions in 1979 to more accurately reflect the workload at that institution.

Efforts to reduce programs will focus on ancillary departments and more specialized areas, since the service demands of virtually all primary care programs make cutbacks undesirable.

CONCLUSIONS

While the New York City Health and Hospitals Corporation is committed to reforming its policies and recruiting and hiring physicians or other appropriate personnel to carry out the duties now performed by FMGs, time is sought to implement these policies before all recourse to FMGs is legally barred.

Other hospitals in New York and other states rely so heavily on FMGs that abrupt termination of their services, as presently called for by the Health Professions Educational Assistance Act, would cause a severe disruption of services in such hospitals.

HHC urges the approval of amendments to the Act which would:

1. Extend the existing period in which waivers from the Act may be sought;
2. Extend the length of time an FMG may remain in this country to complete his medical training before returning to his country of origin;
3. Permit the use of National Health Service Corps physicians in urban hospitals, either as interns or residents or as medical staff.

These amendments would allow all hospitals now reliant on FMGs to gradually abate that reliance and come into compliance with Federal policy on health manpower in hospitals.

TABLE 1

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

HOSPITALS RANKED BY PERCENTAGE OF FOREIGN MEDICAL GRADUATES

<u>HOSPITAL</u>	<u>PERCENTAGE OF FMGs</u>	<u>NUMBER OF FMGs</u>
CUMBERLAND	89	91
GOLDWATER	87	7
GREENPOINT	87	45
LINCOLN	82	133
CONEY ISLAND	69	79
HARLEM	55	147
ELMHURST	51	112
KINGS COUNTY	42	200
METROPOLITAN	36	89
QUEENS GENERAL	27	29
BELLEVUE	23	87
BRONX MUNICIPAL	22	72
NORTH CENTRAL BRONX	18	16

1978 Survey

New York City Health and Hospitals Corporation

TABLE 2

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION AND AFFILIATES

SPECIALTIES RANKED BY PERCENTAGE OF FOREIGN MEDICAL GRADUATES

<u>DEPARTMENT</u>	<u>PERCENTAGE OF FMGs</u>	<u>NUMBER OF FMGs</u>
ANESTHESIA	91.6	184
RADIOTHERAPY	87.5	7
REHABILITATION MEDICINE	86.9	73
THORACIC SURGERY	77.8	14
PATHOLOGY	75.4	126
NUCLEAR MEDICINE	66.7	2
PEDIATRICS	61.3	322
SURGERY	49.2	287
OBS/GYN	41.6	112
NEUROSURGERY	41.2	14
PSYCHIATRY	41.0	134
PLASTIC SURGERY	40.9	9
NEUROLOGY	38.1	32
UROLOGY	36.2	29
ENT	33.3	11
DIAGNOSTIC RADIOLOGY	30.1	53
ORTHOPEDICS	24.7	24
INTERNAL MEDICINE	24.6	246
DERMATOLOGY	14.6	7
FAMILY PRACTICE	10.0	5
OPHTHAMOLOGY	9.0	9

Housestaff Survey 1978

New York City Health and Hospitals Corporation

TABLE 3

RELIANCE ON FMGs BY STATE (1977)*

	<u>PERCENT FMG OF TOTAL</u>	<u>PERCENT OF HOSPITALS OVER 50% FMG</u>
CONNECTICUT	73.2	21.7
NEW JERSEY	58.2	51.1
NEW YORK	41.8	49.1
ILLINOIS	41.5	48.6
DELAWARE	40.6	33.3
MARYLAND	39.1	50.0
MICHIGAN	29.4	41.5
OHIO	28.5	36.0

While all specialties have a substantial number of FMGs, the most dependent specialties in percentage terms tend to be pathology, anesthesiology, rehabilitation medicine, psychiatry, and therapeutic radiology, but in both absolute numbers and percentages, general surgery, pediatrics, internal medicine, and obstetrics-gynecology are also critically reliant upon FMGs. The major voluntary medical centers are less dependent upon FMGs in percentage terms than state, local and other unaffiliated hospitals, but the greater numbers of FMG house staff are found in major hospitals affiliated with medical schools. One type of hospital, however, especially depends on FMGs, namely, the State mental hospital. Above all, the FMG is a critical manpower source for the major metropolitan areas of the country.

*Way, Peter O., "Foreign Medical Graduates in U. S. Graduate Medical Education Programs, 1977," Socioeconomic Issues of Health, 1978, Center for Health Services Research and Development, American Medical Association, Chicago, Illinois, 1978, pp 77-78 as quoted in the New York State Health Planning Commission, May, 1979 report on FMGs in New York City.